RESPONSE OPERATING GUIDELINES

Medical Evacuation

2011

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RECORD OF CHANGES

RESPONSE OPERATING GUIDELINES

MEDICAL EVACUATION 2011

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1	08/1-2011	Updated document for 2011	All	MW

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I. AUTHORITY

See Basic Plan, Section I, and Annex H – Health and Medical. Also, through assignment as primary agency for Health and Medical Emergency Support Function 8 & for the State of Texas in support of Annex C – Shelter & Mass Care, Annex E – Evacuation.

II. PURPOSE & SCOPE

A. PURPOSE

1. The Texas Department of State Health Services, in cooperation with the Texas Division of Emergency Management, has developed this guideline to provide direction to communities and response partners during the evacuation of the medical population during catastrophic events. Although most facilities that care for persons with medical needs are required to have an evacuation plan, there is a strong probability that during an evacuation due to a catastrophic event, some facilities may not be able to execute these plans without the support of local, regional, state and federal partners. If a community requires assistance to evacuate their hospitals, nursing homes, or home health patients, the facility managers and staff and all levels of emergency response (local, state and federal) must work together to provide a well coordinated and efficient evacuation process.

2. This document outlines the various agencies, assets, and operational processes that may be involved in a large-scale evacuation of medical citizens during an emergency event. It describes the roles that local, state and federal partners play in the evacuation process and it describes the various components involved in the evacuation process. This guideline is not meant to supplant local activities but it will provide the framework in which various emergency response agencies will work together to operationalize the response activities associated with a large scale evacuation.

3. The *Response Operating Guideline, Medical Evacuation 2011* will be utilized when local emergency management resources and assets are overwhelmed by the impact of a catastrophic event. It will be utilized to coordinate the needs of the evacuating region's healthcare facilities with efforts of all supporting local, Sate, and Federal agencies.

B. SCOPE

The *Response Operating Guideline Medical Evacuation 2011* , though suitable for most hazards, is primarily focused on evacuations of Medical patients located in coastal communities threatened by a hurricane and located in surge or flood zones. This plan incorporates the steps necessary to provide support to evacuate hospitals, nursing homes and home health patients in a large-scale disaster. The *Response Operating Guideline, Medical Evacuations 2011* also provides guidance to facilities that have taken steps to "shelter-in-place".

III. ACRONYMS & DEFINITIONS

NOTE: These terms and definitions listed below are for descriptive purposes and may not match the terminology of local response professionals.

Aeromedical Marshaling Point (AMP) - is a state/federal designated evacuation point at an airport that is being utilized for medical population evacuation efforts. The AMP provides the specific point where people with medical needs will be transported to at a designated Air Hub. Generally, patients will be transported to the Air Hub via ambulance. Once transferred to the Air Hub and transferred to the medical staff in the AMP, the patient is triaged, prepared for air travel and transferred to an awaiting air asset. They are then flown to designated receiving airport or an NDMS Federal Coordinating Center (FCC) receiving site, where they are triaged and transfer to a receiving NDMS Hospitals by the supporting Veterans Administration or Department of Defense FCC.

Action Request Form (ARF) – An "*Action Request Form"* is the actual form that the state uses to make a request for support from the Federal Government. Both TDEM and DSHS can write an ARF but it must be sent to the supporting federal agencies through the designated person at the State Operation Center.

Air Hub- An Air Hub refers to an airport that has been designated as a collection point for medical patients that will be evacuated out of a region that has been impacted or could be impacted by a pending disaster. An Air Hub can be established by Texas Military Forces or by NDMS or by both. The Air Hub will have medical support personnel at the airport to perform some level of medical support while patients are transferred from a ground transportation unit, triaged to ascertain whether the patient can fly on an air asset, appropriately prepared for an air transportation environment, and loaded on to the air asset.

Air Hub Ambulance Transportation Team (AHATT) – This specifically refers to the Ambulance Strike Teams that transports medical patients from a healthcare facility to the Air Hub.

Air Hub Triage Point or Patient Reception Point – The specific location at an Air Hub where EMS transfers evacuating patients to the air medical transport crews in the AMP.

Ambulance – Medical transportation vehicle capable of transporting up to two patients in a recumbent position.

Ambulance Bus – An ambulance (on a bus platform) that has the capacity and capability to provide care to multiple patients. These are staffed with medical personnel and equipment to support the designated level of care. They are used for mass casualty events and large scale patient transfers of hospital patients and nursing home patients. Texas has multiple units assigned to EMTF regions across Texas.

AmbuBus – Typically a school bus that has been specifically "converted" to provide transportation to medical patients who cannot tolerate sitting for long periods of time, and who do not meet the recommendations for Air and Ground ambulance utilization criteria (see Attachment 5 and the *DSHS Response Operating Guideline – Ambulance Utilization 2011*). This is considered a "last resort" asset utilized in the effort to evacuate medical patients. This

vehicle is staffed with a combination of EMTs, paramedics, and nurses and is equipped with assorted medical equipment to provide care and support to patients during transportation.

Ambulance Deployment Coordination Center – This is the integration of the local EMS System, the designated Medical Operation Center, and the supporting state Ambulance Staging Manager and Medical Incident Support Teams (M-IST) that coordinated ambulance deployments and mission assignments. It is usually centered inside of the local EOC or DDC. Their responsibility is to coordinate requests for medical transportation assets from the ambulance staging area to an evacuating facility to support the evacuation efforts.

Ambulance Providers – This includes the local EMS ambulances and all regional, state and federal ambulances brought into a response to provide transportation assets to a large scale medical emergency event.

Ambulance Staging Manager (ASM) – a team of medical professional capable of providing overall management of an ambulance staging area for large scale deployments of medical transportation assets.

Ambulance Strike Team – a NIMS compliant configuration of five ambulances, assigned to a Strike Team Leader, with common communication capabilities, that is tasked as a group to respond to an event. These teams can be assembled at their dispatch point, at a staging area or by the local Incident Commander.

Ambulance Strike Team Leader – a suitably qualified EMS professional trained to effectively manage and direct an ambulance strike team responding to an event.

Command Assistance Team (CAT) – a designated team of medical professionals employed with DSHS that have been trained to respond to and provide support to the Health Service Region impacted by a disaster.

Comfort Stations – designated sites along evacuation routes that provide support to the general population including rest stations, bathroom facilities, water, and limited medical support capabilities.

Critical Care Air Transport Teams (CCATT) – a DoD medical team that provides in-flight care to critical patients who are electrically or ventilator dependant or require intensive care. Each CCATT team is comprised of an intensivist, a critical care nurse and a respiratory technician.

Department of State Health Services (DSHS) – the lead agency in Texas responsible for health and medical support activity.

Disaster District Committee or Disaster District Coordinator (DDC) – a TDEM regional command and control facility that consists of state/regional response agencies in support of local EOCs. DSHS provides support to the Regional Medical Operation Center (MOC) located within the DDC. The DDC is usually the first point of contact for the DSHS Rapid Assessment Teams and the Medical Incident Support Team.

Diversified Occupation Group (DOG) – A team of specialized medical professionals that respond to a health related emergency and provide specific operational tasks based on their areas of expertise and training.

Embarkation Point – A designated site set up by local officials and the DDC, used as a loading point for people requiring transportation out of a disaster area. The embarkation point should have a medical triage capability and be supported by medical ground transportation assets.

Emergency Operations Center (EOC) – Local emergency command and control facility that provides coordination of response efforts during significant incidents and events.

ESF-8 Public Health and Medical – Emergency Support Function 8 is one of seventeen categories established by the federal government that align categories of resources and provide strategic objectives for their use. The ESF's designate which agencies have the responsibility to perform the specific tasks during a disaster. The Texas Department of State Health Services is the lead agency in Texas for ESF-8 Public Health and Medical support.

ESF- 8 Incident Support Team – Personnel with medical emergency response expertise from various agencies that deploy to a designated location that work together to provide support to all ESF-8 Public Health and Medical related activities involved in a large-scale disaster. The ESF-8 Incident Support Team provides a single point of access for the evacuating region to connect to the state and federal medical evacuation assets. The location of the ESF-8 Incident Support Team will generally be located with the local EOC/MOC or the regional DDC/MOC. This team is often referred to as the Medical Operation Center or MOC.

Evacuation Triage Teams - The mission of the personnel on the Triage Team is to integrate with local jurisdiction triage personnel and assist with triage for appropriate transportation needs and sheltering placement.

Facility Evacuation Team – staff and assets utilized to coordinate the movement of patients within a healthcare facility to a sister facility, non-affiliated facility or transportation hubs. They determine which people to evacuate and prepare them for the transfer to the transportation asset.

Facility Patient Load Officer – staff responsible for triaging individuals and validating the number of patients requiring transportation and the level of transport assistance that is needed. They coordinate with the local Emergency Operation Center (EOC).

Facility Triage Point – a location at the healthcare facility where the Facility Load Officer and the Ambulance Strike Team Leader coordinate the order and sequence in which triaged patients are loaded onto medical transportation assets.

Federal Coordinating Center (FCC) – A reception point at a designated airport that has been established as a receiving location for NDMS patients and civilians with medical needs that are moved utilizing federal medical transportation assets as the result of a large-scale disaster.

Global Patient Movement Requirements Center (GPMRC) – The GPMRC authorizes transfers to medical treatment facilities of the Military Departments or the Department of Veterans Affairs and coordinates inter-theater and inside the continental United States patient movement requirements with the appropriate transportation component commands of US Transportation Command. While the GPMRC is the Department of Defense single manager

for the regulation of movement of military patients, mostly from overseas, it also has a mission to assist federal authorities inside the continental United States in case of natural or man-made disasters, under the system that local emergency responders refer to as NDMS.

H-Hour – the time at which tropical storm force winds touch the Texas coast. Most activities are expressed in terms of how long before H-Hour they are conducted (e.g. Air Evacuation operations cease 18 hours prior to the arrival of tropical storm force winds, or H-18).

Multi Agency Coordination Center/System - COG (COG - MACC) A multi-agency coordination system that responds to requests for resources and support from a local jurisdiction. The Multi-Agency Coordination Center supports response activities that across regions by centralizing and coordinating resource requests and identifying resources that can be obtained from surrounding jurisdictions. It does not have command and control responsibility. The COG MACC provides a formalized process for mutual aid from county to county.

Medical Bus – A regular "coach-style" bus utilized by the Texas Division of Emergency Management (TDEM) and the Department of State Health Services (DSHS) to provide ground transportation to medical patients who have been assessed as being able to tolerate being transported in a sitting semi-reclined position for long periods of time. This medical transportation asset is staffed with medical personnel and equipped with medical equipment to provide supportive care to patients during evacuation.

Medical Incident Support Team (M-IST) - Activities/Objectives
The Medical Incident Support Team is a trained team of medical professionals with emergency response expertise that respond to an event and coordinate the integration of state and federal medical assets into an area impacted by a disaster with the local response and evacuation efforts. These teams of individuals are some of the first representatives of the DSHS ESF-8 response personnel that are deployed into an event.

Medical Operation Center (MOC) – A health and medical unit of an EOC and/or DDC that provides health and medical (ESF-8) support and direction during significant incidents and events using a combination of EMS, hospital, public health, mental health, and emergency management personnel.

Medical Patient – a person with some type of medical condition that requires some level of medical care, support or assistance.

Mobile Aeromedical Staging Facilities (MASF) - federal assets that provide patient holding capability at the Air Hubs. The MASF receives people with medical needs at the Aeromedical Marshaling Point (AMP) and triages patients for airworthiness and ensures patients are properly prepared ("packaged") and loaded onto federal NDMS air transportation assets.

Movement Control Team (MCT) – This term is used to describe the local, state and federal teams of personnel that coordinate the evacuation of patients from medical facilities and maximize the medical evacuation capabilities. This includes the evacuating healthcare facility staff, local Emergency Operations Center staff, Ambulance Strike Teams, Ambulance Deployment Coordination Center staff and state and federal staff.

National Disaster Medical System (NDMS) - assists state and local medical agencies responding to the health effects of peacetime disasters, terrorism, and weapons of mass

destruction. NMDS provides medical response, patient movement, and definitive care capabilities.

Patient Movement Request Form – PMR - This document is a listing of people with medical needs and/or medical patients that need to be evacuated utilizing state and federal medical ground and/or medical air transportation. Any request for TxMF and NDMS Air support of transportation of people with medical needs should come to the DSHS SMOC on the PMR form. It is the key document used by DSHS, NDMS, and TxMF to properly process and develop mission assignments for TxMF and NDMS air transportation assets.

Rapid Assessment Team (RAT) – A team of highly skilled personnel within DSHS that are trained to respond to a disaster threat or event to support the Health Service Region in their mission to conduct needs assessments and assist local and regional emergency responders in the coordination of the ESF-8 response for the agency.

Reception Centers (Air) - A designated area in a receiving community that will be prepared to receive medical patients being sent from an evacuating area by air. This site will provide medical triage, palliative care, and will provide transportation for arriving patients to awaiting shelters, nursing homes, hospitals or other facilities as appropriate. A NDMS receiving site at an airport is called a Federal Coordination Center or FCC.

Reception Centers (Ground) – A designated area in a receiving community that will be prepared to receive medical patients being sent from an evacuating area by ground transportation. This site will provide medical triage, palliative care, and will re-direct patients to shelters, nursing homes, hospitals or other facilities as appropriate.

Shelter-in-Place (SIP) – A safety strategy that requires the occupants of a facility to remain in place while the threat or event passes by.

State Medical Operations Center (SMOC): An interagency (in support of the SOC) health and medical operations center maintained by the DSHS to coordinate public health and medical care response activities above the field level, and to prioritize incident demands for critical or competing resources. The DSHS SMOC facilitates communications between the necessary local, regional, state and federal entities to assemble the assets required to respond to and resolve requests for state public health and medical care assistance.

Temporary Fuel Sites – designated fueling sites along evacuation routes. These sites also provide some medical support (primarily oxygen resupply) to state-operated transportation assets.

Texas Department of Emergency Management (TDEM) – TDEM is the lead agency in Texas for all aspects of emergency response. The Chief of TDEM coordinates all response activity and directs all ESF-8 agencies that provide support to any statewide emergency response.

Texas Military Forces (TxMF) – a combination of Army National Guard, Air National Guard and Texas State Guard whose mission is to provide assistance and security to Texas in times of need.

Texas Emergency Tracking Network (TexasETN) - the Texas Emergency Tracking Network is an internet accessible system that provides emergency responders a way to

record and document the people that they are assisting (be it by sheltering or providing transportation) during a disaster. The TexasETN integrates the Radiant Tracking System and other internet information systems like EMSystems and WebEOC together so that they can share data entered into one with the other systems. This allows users comfortable with one system the ability to share and receive their data with the other systems without having to learn a whole new system. All people provided state transportation or sheltered within Texas are recorded into TexasETN.

TexasETN allows emergency response personnel an ability to see the regions that have received large numbers of evacuees and it assists in proper response planning. It also aids in providing critical information in providing proper levels of medical support and care.

IV. SITUATION & ASSUMPTIONS

A. SITUATION:

1. Hospitals, nursing homes, ambulatory care centers, home bound medical patients, and other facilities for medical/health care of medical persons may be damaged or destroyed in major emergency situations.

2. Medical and health facilities that survive emergency situations with little or no damage may be unable to operate normally because of a lack of utilities or because staff are unable to report for duty as a result of personal injuries or damage to communications and transportation systems.

3. Medical and health care facilities that remain in operation and have the necessary utilities and staff could be overwhelmed by the "walking wounded" and seriously injured victims transported to facilities in the aftermath of a disaster.

4. Uninjured persons who require frequent medications such as insulin and anti-hypertensive drugs, or regular medical treatment, such as dialysis, may have difficulty in obtaining these medications and treatments in the aftermath of an emergency situation due to damage to pharmacies and treatment facilities and disruptions caused by loss of utilities and damage to transportation systems.

5. Hospital administrators and government officials are all cognizant of the fact that movement of any critical care patient from a hospital to any other venue increases morbidity and mortality risks. During a response to a hurricane this fact and the lack of precise predictability of a storm's landfall 48-72 hours pre-event make the decision to evacuate any facility a difficult yet critically important decision.

6. Because of the inherent risks that people with medical needs face during the evacuation of a medical institution facility certain critical-care patients should not be moved unless absolutely necessary. Experts in emergency management and health care endorse the concept of sheltering-in-place and support efforts to harden structures so that patients may be safely sheltered in place.

B. ASSUMPTIONS

1. Most communities have adequate local response capability to meet most emergency situations.

2. Health care facilities have viable emergency evacuation plans.

3. The administrators of each healthcare facility, in close coordination with their local officials and emergency management, determine the need to evacuate or shelter-in-place.

4. If hospitals, nursing homes, and homes with people with medical needs are threatened or damaged, it may be necessary to relocate significant numbers of patients to other comparable facilities elsewhere.

5. Local and regional authorities will utilize the capabilities of volunteer agencies (i.e. Medical Reserve Corps (MRC), Citizen Corps, Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), etc.) professional associations, and other non-governmental agencies to support the evacuation and response to the emergency.

6. A large scale catastrophe could force the evacuation of so many people with medical needs that a community will have to obtain additional medical transportation assets, response personnel and medical support teams from local, regional, state and federal response partners.

7. The scope and severity of the emergency, as well as other direct or indirect threats presented by the emergency, will determine which patients/facilities will be evacuated and which air hubs and embarkation sites will be activated to facilitate the evacuation efforts.

8. The procedures for evacuation outlined in the "Response Operating Guideline Medical Evacuation 2011" are primarily designed to be used during events that receive a state or federal declaration of disaster.

9. The intent of the "Response Operating Guideline Medical Evacuation 2011" is to provide a roadmap to assist in the evacuation efforts of the local healthcare facilities and home bound medical population, by coordination emergency operation activities of local responders with the supporting local, state, or federal agencies.

10. The "Response Operating Guideline Medical Evacuation 2011" does not provide for the simultaneous evacuation of medical facilities in all coastal counties.

11. All requests for assistance related to the evacuation of a community's medical population and medical facilities will follow the normal channels of requests for support from the community through to the County, the regional DDC, the State Operations Center (SOC) and Federal Government (see Attachment 6).

12. Once a formal request is received and approved, state and federal agencies will be focused on providing support to regions that make the decision to evacuate their medical facilities and home bound medical population, and to assist in providing support for the care of the medical population that was either evacuated or took steps to "shelter-in-place".

V. CONCEPT OF OPERATIONS

A. GENERAL

1. All medical evacuation response operations will follow the National Incident Management System (NIMS) and the National Response Framework (NRF) structure.

2. When a catastrophic event occurs or is pending (such as a hurricane response) with the potential for serious impact on the health and safety of people in Texas, DSHS will activate the DSHS State Medical Operation Center (SMOC) to maintain contact with the impacted jurisdiction, monitor the incident, facilitate the processing of local requests for assistance, and act as a liaison to other supporting state agencies, ESF-8 partners in other states, and our federal and private partners.

3. In certain disasters or public health emergencies, DSHS may determine the need to preposition state medical assets and personnel.

4. Local requests for surge equipment, supplies, and personnel should be made according to established protocols for emergency assistance requests as outlined in the State of Texas Emergency Management Basic Plan. This should be done in coordination with emergency management officials, the Local Health Department (LHD) or Health Service Region (HSR) office in counties without local health departments.

5. Activation criteria during a hurricane:
   The "Response Operating Guideline Medical Evacuation 2011" provides information to assist local, state and federal responders deliver a well coordinated response to a potential event. The operation activities that will be carried out will be determined based on the following criteria:

   - Strength of the Storm – The strength of a storm is determined by many characteristics including the size of the storm, the wind speed of the storm, potential storm surge, and speed that the storm is traveling.

   - Direction of the Storm – There is no precise method to predicting a storms path and potential impact site so, at 60 to 70 hours prior to landfall, a hurricanes potential impact sites can span a large area of the coast. The unpredictable nature of a storms path forces local, state, and federal emergency management leaders to make decisions on potential impact areas based on what weather experts call a "cone of error". In order to protect and evacuate as many people as possible a stronger storm may force officials to move patients on a "maybe" event.

   - Local Factors – A decision by local officials to enact a voluntary or mandatory evacuation will also impact facilities efforts to acquire assets and maintain staff during an evacuation effort. This may require a facility to evacuate even though the structure is designed to withstand the potential impact of the storm.

B. OPERATIONS

The following are guidelines to facilitate coordination, interagency communications, and operational functionality during the four phases related to a disaster response, including awareness, preparedness, response, and re-entry. Healthcare facilities are responsible

for having evacuation plans, including contracts or agreements in place to execute them. However, large-scale medical evacuation of an entire region or multiple regions will require private, local, state, and federal assets to accomplish the mission. Individuals with medical needs have the responsibility to self-evacuate whenever possible. Those who cannot self-evacuate may require assistance from the city/county and other local entities. If local counties are overwhelmed by the demand for medical evacuation, assistance from the state and federal ESF-8 partners will be required. State and federal assistance includes all agencies and their operating teams required to successfully execute a medical evacuation and sheltering plan.

1. **Awareness Phase**
   During this phase, state and federal ESF-8 partners review current response plans, with a focus on identifying and filling resource gaps. Transition out of the awareness phase is contingent upon multiple factors including notification of an incident or potential emergency. During hurricane season it occurs when a tropical depression/storm enters the Gulf of Mexico, the storm's five day cone touches the Texas coast, or the intensity reaches a category three while having the potential to impact the Gulf Coast.

2. **Preparedness Phase**
   This phase begins when there is a notification of a significant incident and the resources of the state and federal government may be requested or, during hurricane season, a tropical depression/storm enters the Gulf of Mexico, the storm's five-day cone touches Texas coast, or the intensity reaches a category three while having the potential to impact the Gulf Coast. Once an emergency declaration is made by local, state, or federal officials, resources and assets will begin to stage and deploy to designated locations in order to assist the affected areas. The intensity, available resources, and projected track of the storm will determine the amount of ESF-8 assets deployed.

   The Texas Division of Emergency Management (TDEM) will activate the SOC and the Department of State Health Services (DSHS) will activate the DSHS SMOC. If Federal support agencies (FEMA Region VI, National Disaster Medical System (NDMS), DoD, et al) activate and respond they will co-locate and coordinate ESF-8 activities in the SOC and the DSHS SMOC.

   a. The ESF-8 staffing at the SOC and the DSHS SMOC will be determined by response requirements and validated state requests.

   b. State and DSHS H-120 hour plans are activated and appropriate action steps initiated.

   c. The SOC and DSHS SMOC, in coordination with federal partners and local officials, determine which regional medical staging areas, Air Hubs, and Medical Shelters will be activated.

   d. The potential impacted Health Service Regions and Trauma Service Areas establish communication processes with the DSHS SMOC in order to coordinate all ESF-8 response activities.

   e. Medical Facilities

1) Review their evacuation plans and determine which patients can be discharged if necessary, which patients may shelter-in-place, and which patients may require evacuation.

2) Organize clinical staff for shelter-in-place capability.

3) may cancel elective surgeries to reduce patient totals.

4) Alert their predetermined transportation contractors to prepare to deploy assets to support evacuation.

5) Alert and maintain communications with their receiving facilities.

f. Local 911 providers continue to respond to 911 requests, identify the assets they will need to augment their operations, and identify where outside support assets and agencies will report.

g. Coordination with other Emergency Support Function partners is initiated in preparation for evacuation and sheltering.

h. DSHS mobilizes ambulances from outside the possible zone of impact to medical staging points to integrate with local 911 providers (Note: the initial state staging location for medical transportation assets is at the San Antonio Alamo Regional Command Center (ARCC). These assets are then assigned to the DDC region(s)for further deployment to local jusridictions.

i. DSHS response teams (ex: Rapid Assessment Team (RAT) and Medical Incident Support Team (M-IST), Ambulance Staging Strike Teams and Ambulance Staging Managers) are notified for potential deployment.

j. Federal ESF-8 will alert its partners to prepare for deployment to Texas to support evacuation and shelter operation.

1) Once Action Request Forms (ARF's) are received from the state and approved at the federal level, contracts are activated for Federal ambulances, para-transits and coach buses. Once the State of Texas or county officials order a mandatory evacuation and after a Pre-Landfall Presidential Emergency Declaration, Federal assets (including Federal Medical Station material caches and personnel) deploy to augment state and local assets.

Note: Action Request Forms are submitted through the State Operations Center. Only the TDEM and DSHS fill out and file ARFs. For DSHS, the Operations Section will obtain the necessary operational information, fill out the ARF, and file it ***through*** the State Operations Center.

2) HHS will alert NDMS for: possible deployment of teams, evacuation of patients, and reception at FCC. Once deployment orders are issued, DoD, the lead agent for evacuation transportation within the NDMS, provides assets required to evacuate patients from Air Hubs to a Patient Receiving Area (PRA) as determined by the Medical Interagency Coordination Group (MIACG).

3) HHS will stage NDMS teams to assist at the Medical Shelters, Air Hubs, and Federal Medical Stations (FMS) as required.

k. Staging operations are activated in San Antonio ARCC, DSHS Division 2.

3. **Response Phase**
This phase begins with the mandatory order to evacuate. The storm intensity and location will dictate the extent of the evacuation and destination of evacuees.

a. Medical institutions, including hospitals and nursing homes will decide whether to evacuate, shelter-in-place, or a combination of both. The home bound medical population will receive evacuation orders from local officials. Initial evacuation efforts will primarily focus on ground transportation. Air operations will be initiated only if ground transportation efforts are unsuccessful or cannot meet the demand for evacuation of the medical population. Federal NDMS Air operations are a last resort effort to move people with medical needs out of an impact site.

b. All medical facilities will provide their respective Emergency Operations Center/Medical Operations Center (EOC/MOC) with key information of their status as requested by their EOC/MOC.

c. Local and state officials will determine where to locate Medical Shelters and Federal Medical Stations (FMS) to be available to receive medical population. **See the DSHS Response Operating Guideline – Shelter Operations for details.**

d. People with medical needs that live amongst the general population will either evacuate from Embarkation Points utilizing local, state and federal transportation assets *or self-evacuate*. Those home bound people with medical needs that cannot self evacuate must notify their respective EOC or 2-1-1 providers to request evacuation assistance. The medical population evacuated on state assets will be transported to a safe facility in their jurisdiction *or* to a receiving jurisdiction and directed to a Medical Shelter, nursing home, or hospital depending on medical needs.

e. Medical facilities request ground evacuation through their local EOC/MOC. Coordination of the dispatch of ground transportation assets to a facility is coordinated through the local EMS system and the EOC/MOC. If local EMS requires augmentation, the EOC/MOC will coordinate with the regional DDC/MOC and the Medical Incident Support Team (M-IST) to obtain additional resources from the designated Ambulance Staging Area. Any additional support needs for medical transportation assets are forwarded to the regional DDC and up the chain to the DSHS SMOC Evacuation Branch. All facility evacuations and patient movements are reported to the respective EOC, DDC, and SOC (DSHS SMOC) via the designated process.

f. The ESF-8 Support Team (designated MOC staff) and the designated M-IST personnel will work to coordinate dispatch of medical buses and para-transit units to ambulatory people with medical needs as needed.

g. When possible, ambulances and buses will depart simultaneously from the staging area, in a Medical Transportation Strike Team format.

h. When medical transportation assets arrive at a medical facility, the designated *Facility Patient Load Officer* will work with the Ambulance Strike Team Leaders to coordinate the loading of patients onto ambulances and buses. Upon completion of the evacuation of the facility the Load Officer will notify all appropriate EOCs. Patients will be transported to Air Hubs, receiving jurisdictions, medical shelters,, hospitals, and long term care facilities as appropriate.

i. The Medical Operation Centers and the M-IST personnel will coordinate all transportation missions with the DDC, EOC and embarkation points.

j. Between 18 and 12 hours prior to the onset of tropical storm force winds touching the coast of Texas, all patient evacuation operations will cease. At this point, if required, Urban Search and Rescue (USAR) Operations will begin. **No later than H-12 all aeromedical response personnel will begin movement out of the impact area and into a safe haven.**

k. When the hurricane passes and it is presumed safe, evacuation and/or rescue operations will resume, if required.

l. Search and rescue of medical facilities needing evacuation after the storm will commence, with those most needing rescue retrieved first (Smart SAR). This activity will be coordinated through Texas Task Force 1 and other SAR support agencies. Ambulance Strike Teams and Ambulance Strike Team Leaders will be deployed with the USAR teams to assist in their rescue operations.

m. Damage and Medical Needs Assessments will be conducted for all medical facilities and in coordination with the state and remaining response requirements identified.

4. **Re-Entry Phase**

This phase is initiated as soon as possible after the event has occurred. In a hurricane this occurs after tropical storm force winds have subsided. The State of Texas has developed specialized teams of emergency response experts from multiple Emergency Support Functions (ESFs) that are deployed into the disaster area to do damage and needs assessments. These personnel and teams, operating under the authority of the State of Texas, will be activated by the Texas Department of Public Safety Assistant Director, Emergency Management or his/her designee, when deemed appropriate. The personnel are designed and intended to assist local authorities by assembling, entering, and coordinating the resources necessary for the provision of:

a. Security of the involved area

b. Acute medical care

c. Mass care

d. Evacuation

e. Support of sheltering needs

f. Re-establishment of vital infrastructures during the pivotal time period immediately following a devastating storm or other significant event.

C. DSHS RESPONSE ACTIVITIES

When a large scale disaster impacts a community the ability to provide care and/or evacuate large numbers of people with medical needs can severely challenge a community's medical response system. In some disasters the effort to safely move the medical needs population out of harms way will often necessitate the need for the combined resources of local, state and federal response partners. With a finite amount of ground and air medical transportation assets, all emergency response professionals must work together to effectively manage these critical assets and safely evacuate the medical needs population from hospitals, nursing home, home bound people with medical needs, embarkation points, and Air Hubs.

Many processes and procedures utilized by the supporting agencies during a large scale evacuation will be presented in this guideline. Although the complexities of each agency's missions may not be described in detail there should be enough information included in this document to give local emergency response professionals an understanding of how the various supporting agencies are brought in to provide support to the medical evacuation effort.

D. INITIAL RESPONSE

For a no notice event the DSHS response activities will be initiated once DSHS is aware of the emergency. For a notice event like a hurricane DSHS will align its response with the State Operation Center, utilizing pre-established time lines to initiate operational actions. Although each and every disaster delivers a unique set of challenges the ***initial*** operational response activities are similar:

- Establish situational awareness and conduct a needs assessment
- Develop an operation command structure for the event and establish communication links with all supporting agencies
- Procure and deploy the necessary assets identified during the needs assessment that will support the local operational response
- Initiation of operational response activities and monitor the emergency events and adapt the response operations accordingly

1. Establish Situational Awareness/Needs Assessment

As the state's designated lead agency for ESF-8, the Department of State Health Services provides health and medical support during a catastrophic disaster or health emergency. For disaster events that would require a large scale evacuation like a major earthquake, flooding, or hurricane, DSHS works with local, regional, state and federal partners to provide assistance and support to the impacted regions.

The Department of State Health Services (DSHS) establishes situational awareness and starts the process of building an appropriate operational response by activating and/or deploying the following:

a. DSHS activates the DSHS SMOC and this serves as the State Medical Operation Center. Located at the main campus (1100 W. 49th Street, Austin, Texas), the DSHS SMOC supports the SOC for ESF-8 allocation of resources and provides coordination and communication of all ESF-8 activities within the State of Texas.

   1) Establishes communications with Health Service Regions

   2) Coordinates with the SOC and the Texas WebEOC Interoperability Project (TWIRP) to create a Statewide Incident in the Texas WebEOC Fusion Server to integrate with all WebEOC instances that will be effected by or supporting the incident

   3) Assists in the establishment of the TexasETN during large scale evacuations

   4) Establish communication links with regional MOCs that will be impacted or are activated to provide support to DSHS

      a) Activates the Catastrophic Medical Operations Center (CMOC) located in Houston for Division 1 as appropriate for state level activities

      b) Activates the Regional Medical Operation Center (RMOC) located in San Antonio for Division 2 as appropriate for state level activities

   5) Establishes conference call schedule for the DSHS Health Service Regions and Regional Advisory Councils

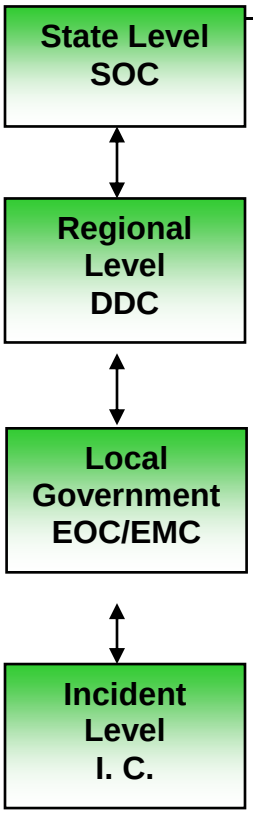
b. RAT and M-IST: DSHS has developed several different response teams that will be activated to respond to an impacted region to provide assistance and support. Two of the first teams to be activated and deployed into a region will be the DSHS Rapid Assessment Team (RAT), and the DSHS Medical Incident Support Team (M-IST).

   1) The RAT works with local officials and the DDC to conduct an assessment of the impact the event will have on public health systems and develops situational awareness for the SMOC and helps determine what the support needs are.

   2) The M-IST are deployed to an evacuating region to work with local response officials, EOC-MOC, DDC-MOC, to coordinate the requests for transportation of medical needs people, coordinate the staging of medical transportation assets, manage the assets, and coordinate the evacuation and tracking of people with medical needs out of harms way to a safe location.

   3) Establish communication links with local, state and federal supporting response agencies:

2. **Develop ESF-8 Operation Command Structure**



State Level
As a member of the SOC Emergency Council responsible for all ESF-8 Public Health and Medical related activity, DSHS provides response support through the DSHS SMOC.

Regional Level
DSHS and the DSHS Health Service Regions support the designated DDC, their Medical Operations Center, and other regional response partners.

Local Government Level
Mayor, County Judge, and the Emergency Management Coordinator (EMC) make requests for any health and medical needs to the DDC. Local public health supports the local EOC.

Incident Level
Incident Commander - Makes requests for support to the local government for any health related needs.

a. The State of Texas has developed a command structure that allows local government to effectively manage their response efforts while working with the state to acquire additional support and assets. Any and all requests for assistance from a local government must follow this established state process. Utilizing this process during a response to a disaster will provide more effective incident management, improve communication processes, and assist the state and federal government in responding to and coordinating the requests for assistance and support.

b. Designated representatives from the Department of State Health Services Health Service Regions and the RAT and M-IST response teams will meet with the DDC and EOC officials as appropriate to formalize the communication processes for health and medical related operations. The designation of a formal Medical Operations Center (MOC) within the EOC and/or DDC will help develop the necessary communication links between local response agencies and all supporting state and federal agencies that will respond to support health and medical activities. In addition to this established state process, the Department of State Health Services has developed an ESF-8 command, communication and coordination structure. See Attachment 6 for details of this structure.

c. For the purposes of coastal county evacuations that require assistance of state or federal resources the Department of State Health Services (DSHS) divides the

State of Texas into two geographic divisions and utilizes two regional Medical Operation Centers (MOC) to provide enhanced command, coordination, and communication of medical activities. The CMOC in Houston is utilized in Division 1 and the RMOC in San Antonio in Division 2. Emergency Response officials in local communities are advised to contact the appropriate staff of these two MOCs to establish communication processes and discuss operational aspects related to a large-scale disaster.

1) Division 1 (Houston): Division 1 includes contiguous counties along the Texas coast that are located between the Sabine River in eastern Texas to the Matagorda County/Jackson County line at the northern end of the coastal bend. Houston is the regional point for staging and evacuation support of this division of coastal counties. Designated as the regional staging area for Division 1, numerous resources and activities are conducted in Houston in support of coastal evacuations. TDEM and DSHS will utilize the designated staging location (site to be determined) to store medical supplies and equipment, and to stage medical assets including transportation vehicles and personnel.

   The command and control of staging operations in Houston are coordinated at the DDC. All ESF-8 activities conducted by DSHS are coordinated through the DDC utilizing the following resources:

   a) DSHS Health Service Region 6/5S and Health Service Region 4/5N.
   b) CMOC in Houston.
   c) RMOC in San Antonio.

2) Division 2 (San Antonio): Division 2 includes contiguous counties along the Texas coast that are located from the Matagorda County/Jackson County line to Brownsville at the lower end of the Rio Grande Valley. San Antonio is the regional point for staging and evacuation support for this division. Designated as the regional staging area for Division 2, numerous resources and activities are conducted in San Antonio in support of coastal evacuations. TDEM and DSHS will utilize the designated staging location in San Antonio to store medical supplies and equipment, and to stage medical assets including transportation vehicles and personnel.

   The command and control of staging operations in San Antonio are under the DDC. All ESF-8 activities conducted by DSHS are coordinated through the DDC utilizing the following resources:

   a) DSHS HSR 8
   b) RMOC San Antonio
   c) Southwest Texas Regional Advisory Committee (STRAC)

d. Other supporting Agencies including the HSRs, RACs and local public health partners are utilized to assist in gathering ESF-8 related information including: facility statuses, available hospital beds, conditions of End Stage Renal Disease

(ESRD) facilities, shelter usage reports, and other medical and public health related activities in their regions related to a large scale disaster.

3. **Procurement and Deployment of Assets**

   a. As has been mentioned, a large disaster will quickly overwhelm the capacity of most local emergency response systems and medical systems. The demand for medical transportation assets is going to quickly utilize all locally available resources so there will be a strong need for additional support. The efforts to activate and deploy the RAT and M-IST response teams and work with local officials to establish a communication process provides two benefits; one, it allows the DSHS response teams to work with the local emergency management officials in identifying the assets needed to support the local response efforts and two, it develops the communication links that are necessary to properly coordinate the arrival and management of the medical transportation and medical care assets that are utilized during a large scale disaster response.

   b. The request process for local government to request assistance and resources from the state follows the pre-identified communication process. The actual form utilized to make a resource request is called a 213RR (see attachment 11). This form can be processed through normal communication mechanisms up to the State Operation Center (SOC) or it can be processed electronically utilizing the WebEOC 213RR. The recommended method is to utilize the electronic version of the 213RR that was developed and built into WebEOC. For details and/or questions on this process contact your regional emergency management coordinator or your local WebEOC Administrator. Additional support can be obtained by contacting the Texas WebEOC Interoperability Project (T.W.I.R.P.) at the following e-mail address: support@strac.org or by phone at 210-233-5888.

4. **Initiation of Operational Response Activities for DSHS**

Local emergency management officials have the responsibility to determine if they should evacuate OR shelter-in-place. If the officials determine they must evacuate and they need assistance utilizing state and federal resources then the Section E. Evacuation Operations of this response operating guidelines will be utilized.

The decision to Shelter-in-Place – Local emergency management officials and the facility administrators should consider all aspects of their operations when deciding to "shelter-in-place". Facility administrators that decide to shelter-in-place must plan accordingly and have a 96 hour * supply of the following assets:

   a. Availability of staff to support on-going operations, including having a policy that addresses support of staffs' immediate family members

   b. Availability of generators and sufficient fuel to support emergency power needs, including some or all of the facility's HVAC systems

   c. Security measures in place

   d. Food and potable water

   e. Medical supplies, including pharmaceuticals, dressings, disposable gloves, etc.

f. Emergency room operations

g. Utilities, including communication and waste water systems

h. Linens

i. Oxygen and other medical gases

j. Activation of existing mutual aid agreements, memorandums of understanding or contracts to augment staffing when sheltering-in-place.

Note: This 96 hour time frame is a Joint Commission on the Accreditation of Health Care Organizations (JCAHO) requirement. DSHS and TDEM recommended that any facility that opts to shelter-in-place should have at least a 5-day supply of the above listed assets. Recent experiences with hurricanes indicate that there can be a disruption infrastructure including electricity and water supplies for up to 14 days.

E. EVACUATION OPERATIONS

1. TDEM and all Emergency Support Function agencies will work together to assist any community requesting assistance to evacuate during a large scale disaster.

2. In general, ground evacuation is the first and primary mechanism of transportation that will be utilized during an evacuation. Because of the difficulty of establishing and utilizing air transportation assets, every effort should be made to evacuate utilizing ground transportation as the primary choice for evacuation. NDMS and TxMF air transportation assets will be utilized as a final method of transportation should the need arise.

3. **If any medical facility (hospital, nursing home, home bound patient with medical needs) determines they must evacuate for any reason, <u>the local EOC must be notified</u>.** This notification is required even if the facility has resources available to complete a self-evacuation. This notification advises local authorities of the potential reduction in anticipated medical assets, including the loss of the facility AND the loss of other medical transportation assets.

4. If a facilities plans for self-evacuation have failed the facility manager shall make a request for assistance by notifying their local EOC. The local EOC/MOC will either carry out the request and assist in the evacuation or submit the Patient Movement Request (PMR) to the DDC utilizing the established process. The DDC will either support the request and carry out the ground evacuation or, if aeromedical evacuation support will be necessary, they will submit the designated PMR to the State Medical Operation Center, ESF-8 desk.
   a. The SMOC Operations Section will evaluate the PMR and determine if federal assistance is necessary and then work with the Federal GMPRC team to process the PMR into the National Disaster Medical System (NDMS).

   b. The SMOC Operations Section will then work with local, state and federal partners to coordinate and provide the necessary assets to the local community in support of their evacuation mission.

5. If the healthcare administrator makes the decision to begin evacuation of a healthcare facility the healthcare facilities responsibilities include:

    a. Activation of the facility emergency operations plan

    b. Notification to the local EOC/Medical Operations Center of:

        1) Intent to evacuate

        2) Numbers and acuity levels of patients that require medical transportation utilizing the designated process outlined by their EOC/MOC. Note: the local EOC/MOC must have this information in order to identify the proper type and quantity of medical transportation assets required to evacuate the people with medical needs. If assistance is needed to identify and categorize persons they can request assistance to the EOC or DDC. Personnel in the MOC from local public health, Health Service Region and DSHS (such as M-IST) will assist in providing support for to an evacuating facility.

        3) Location where the patient(s) are being evacuated.

        4) The need for assistance in locating an evacuation location appropriate for the needs of the patient population.

    c. Adequate inventory of essential personnel and resources to respond to the disaster OR a request for the need of additional personnel.

    d. Triage of patients and preparation of patients for transport (See section on Triage and the **Response Operating Guideline - Ambulance Utilization 2011**). Each facility should identify a lead person to provide coordination and communication for identification and movement of their facility's medical population. The facility should also assign a team of personnel that are assigned the job of preparing and facilitating the movement of people from the facility (hospital, nursing home) to the awaiting medical transportation assets. DSHS uses the terms "Facility Patient Load Officer" and "Facility Evacuation Team" (see definitions) to identify these personnel.

    e. Provide the name(s) of medical support staff that will travel with the patient and assist in providing medical care during transport.

Note: If the local EOC/MOC does not have sufficient ground transport asset to move all medical patients and Air Operations must be requested, the designated Patient Movement Request (PMR) should be filled out and processed through the communication chain to the to the SOC ESF-8 DSHS SMOC. The M-IST can assist in the processing of this form. The early processing of the PMR will allow DSHS, Texas Military Forces, and NDMS to develop the mission assignments for air operations.

    g. The facility personnel (Facility Patient Load Officer and the Facility Evacuation Team) will follow their established protocols in order to execute a safe and efficient evacuation of the patients.

1) Hospitals that have contracted for private air and ground ambulance assets and can execute their plan without state or federal assistance will use the designated airport identified in their respective plans. Hospitals utilizing these private contract operations will not use any designated state or federal established Air Hubs for their evacuation operations.

2) The local EOC is responsible for command and control of the evacuation process once a request for assistance has been made by a medical facility. The local Emergency Operations Center (EOC) will be supported by local response agencies (EMS, fire, and law enforcement) and the local Medical Operations Center – MOC.

3) DSHS Support Teams such as RAT, CAT, M-IST, ASM, Triage Teams, Bus Teams, etc., will all work to support a facility and local communities evacuation efforts.

F. TRIAGE

In a large-scale evacuation all persons being evacuated should be triaged prior to transportation on any state and/or federal transportation asset. Triage of the evacuating population should be conducted in two distinct phases, the evacuation phase (for transportation needs) and the reception phase (for sheltering needs).

Note: *Attachment 5 "Air and Ground Ambulance Use Criteria from GETAC*", *"NDMS - Absolute Contraindications for Flight*", and *"TxMF - Aero-Medical Evacuation of Inpatients in a Disaster"* provide emergency response personnel and medical officials with criteria on how to properly select the most appropriate transportation asset for the movement of their population with medical needs, thus allowing for the most effective and efficient use of all medical transportation assets during a large-scale evacuation.

DSHS Evacuation Triage Teams

The Texas Department of State Health Services has trained personnel in the policies and procedures of triage for evacuation and for sheltering. These personnel will be deployed as needed to areas that are evacuating to assist in the task of triaging patients during a disaster.

1. **Triage during the Transportation Phase:** In the evacuation phase, all people will be assessed to determine if they have a medical need that requires a special medical transportation asset for their safe evacuation. The assessment will occur at the medical facility, ground embarkation point and air hub. Those with medical needs will be transported on the following:

   a. <u>Ground assets</u>

      1) Ambulance
      2) Ambulance Bus
      3) AmbuBus (medical conversion bus)
      4) Specialty Ambulance (i.e.: Bariatric capable, pediatric capable)
      5) Medical Bus

b. Air assets

1) Fixed wing-plane
2) Rotor wing-helicopter
3) Specialty air transport (i.e.: neonatal, ICU capable, etc.)

It is highly probable that a person with medical needs will be assessed and triaged more than one time in order to make sure the person is placed on the correct transportation asset. For example: A patient can be triaged at a hospital where it is determined there that the person should be flown out. When the patient arrives at the Air Hub and is triaged again it may be determined that the patient cannot survive the air transportation. A decision on an alternate method of care and transportation would then be made. The goal of triage is to make sure the person is on the right mode of transportation and that the patient is healthy enough to survive the movement during an evacuation. **For further information see "Response Operating Guideline - Ambulance Utilization 2011.**

2. **Triage during the Sheltering Phase:** In the sheltering phase, people with medical needs will be assessed to establish their post transportation condition and determine which type of facility can best address their medical conditions. It is very important to understand that the physical condition of citizens leaving a community could greatly diminish during the transport. Citizens that arrive at reception points, whether it be a reception center, an Air Hub (NDMS or TxMF), or a shelter site, will have to be re-evaluated, provided with stabilizing medical care, and then triaged in order to determine the most appropriate facility to place the individual into; be it a general population shelter, medical shelter, long term care facility, nursing home or acute care hospital.

For further details see the DSHS Response Operating Guideline – Medical Sheltering Operations 2011.

G. AMBULANCE UTILIZATION

Experience with major catastrophes has shown that, during any large scale disaster, there is a very finite supply of medical transportation assets. Therefore it is critical that these assets be properly managed and utilized throughout a response to an event. To address this need the DSHS has developed specific criteria on how medical transportation assets will be utilized during a catastrophic emergency. **The information can be found in the Response Operation Guideline – Ambulance Utilization 2011.**

H. DETERMINING THE MODE OF TRANSPORTATION

The decision as to what type of asset a person with medical needs will be transported on is determined by medical guidance and availability of the prescribed assets. In a large-scale emergency evacuation, the demand for air and ground transportation assets is extremely high and the supply is limited. This fact may alter established protocols for medical transportation under normal circumstances.

1. **Medical Ground Transport**

Assuming they are fit to travel, people with medical needs will be transported by ambulance, ambulance bus, medical bus, ambus, para-transit vehicles, or litter bus based on their medical needs and available assets.

a. Transports/Transfers types:

1) Patients may be transported from an evacuating institution to an awaiting institution in a facility-to-facility transfer.

2) Patients may be transferred from an evacuating institution to a designated Air Hub (See Air Transportation). The EOC/MOC, local EMS and the Air Hub Ambulance Transportation Team (AHATT) coordinate the movement of these ambulances.

3) Patients may be transported from the evacuating institution to a reception point in a receiving community Reception Center or Staging Area, where they will be triaged and transferred to an appropriate medical facility, assisted living facility, or medical shelter. Local jurisdictions will establish these reception centers and staging areas.

4) Patients may be transferred from an evacuation Embarkation Point on a state medical ground transportation asset, and then to a receiving community's Reception Center where they will be triaged, and transferred to an appropriate medical facility, assisted living facility, or medical shelter.

b. Ground Transportation assets will come from the following sources

1) Local medical transportation resources (both private and municipal) will be supplied from the local EMS system and/or private contractors until this resource is exhausted or unable to support the evacuation mission.

2) Regional medical transportation assets will be requested by the EOC through activation of their mutual aid agreements with surrounding jurisdictions and through the local region's Multi Agency Coordination Center.

3) State and/or federal medical transportation assets (ambulances, ambulettes, ALS buses, etc) will be requested by the EOC/MOC to the appropriate DDC.

a) The DDC will make a request to the SOC and the assets will be deployed to the requesting region from the state staging area in the San Antonio ARCC.

b) Once deployed to a region, the medical transportation assets will be staged in the evacuating region's designated staging locations. These "Forward Staging Areas" and will be under the direction of the region's DDC.

4) State staging area in San Antonio at the ARCC.

a) DSHS, the HSR and the STRAC provide overall management of the medical transportation assets staged at this location.

b) Requests for these assets follow the established state requesting procedures.

5) Regional Staging Area - the Forward Staging Areas.

a) This staging area is located in or near the evacuating region at a location established by the requesting DDC (Note: there may be more than one of Regional Staging Area).

b) Ground assets staged in San Antonio will be deployed into the Regional Staging Area as determined by the storm and requests that come from the DDC regions.

c) The requesting DDC must anticipate and plan for logistic support for these assets.

d) Ambulance Staging Managers - DSHS assigned M-IST and Ambulance Staging Managers will assist in:

- locating a suitable staging area
- provide oversight and management of deployed medical transportation assets
- support for the Regional Staging Area and assist in requesting logistical support through the regional DDC.

6) Requests for ground transportation assets will be made to the EOC and through to the DDC as necessary. Assets will be deployed from the Regional Staging Area to the following:

a) A specific mission assignment for a patient transfer – facility to facility.

b) A specific mission assignment of a facility transfer – facility to reception point.

c) An Embarkation Point to reception point.

d) As part of an AHATT – facility to an Air Hub.

7) All requests for ambulance assignments will be coordinated through the Medical Operation Center supporting the DDC. The DSHS M-IST and the medical professionals coordinating ESF-8 activities will provide expertise in the deployments of Ambulance Strike Teams and other medical transportation assets.

8) For further details see the Response Operation Guideline – Ambulance Utilization 2011.

c. Ground evacuation route Fueling Stations and Comfort Stations

1) State Fuel Stations and State Comfort Stations are supported by the Texas Military Forces.

2) Fueling Stations – most state evacuation routes have fueling stations that provide diesel fuel for state transportation assets.

   a) Buses and ambulances can refuel at these locations if they use diesel fuel.

   b) Ambulances and medical buses can obtain oxygen re-supply at these locations.

3) Comfort Stations are designated points along an evacuation route that provide support to the evacuating general population. They are separate and distinct from a Fueling Station.

   a) Private vehicles can obtain water at these locations

   b) Basic medical support may be provided by local EMS

2. **Air Transport**

a. General: It is highly probable that the evacuation efforts of a community may require augmentation by state and federal air assets. State and federal support for Air Operations during a large scale evacuation can actually fall into several categories:

   1) Movement of non-medical civilians utilizing contracted civilian aircraft and military aircraft.

   2) Movement of medical patients utilizing contracted small fixed wing aircraft and/or rotor wing medical helicopters, sometimes referred to as Air Ambulances.

   3) Movement of medical patients utilizing large military aircraft such as C-17's and C-130's.

b. All medical air missions will require intricate coordination between the local EOC/Medical Operation Centers, the medical facilities, the supporting agencies providing air transportation operations, receiving jurisdictions, and medical facilities.

c. MEDICAL POPULATION people evacuated by air will be transported by fixed wing aircraft (planes) and/or rotor wing aircraft (helicopters) based on patient needs and available assets.

   1) Transfers from a facility on

      a) Rotor Wing (Helicopter)
         - Facility-to-facility utilizing heliports
         - Facility to Air Hub
         - other transportation mission

b) Fixed Wing (Planes)

- TxMF - From a medical facility to a designated Air Hub:
  - Patients are transferred from a hospital, nursing home, or home health facility by ground ambulance or a rotor wing asset to an Aeromedical Marshalling Point (AMP) at a designated Air Hub
  - Patients are triaged by on site medical staff at a designated Air Hub and made "flight ready"
  - Patients are transferred to the evacuating aircraft
  - Patients are flown to a receiving airport

- NDMS – Hospitalized Patient from hospital facility to an Aeromedical Marshaling Point (AMP) at a designated Air Hub, to a designated NDMS Patient Receiving Area (PRA) at an FCC (receiving Air Hub).
  - Patients are transferred from a hospital facility by local or state ground ambulance or rotor wing asset to a designated Aeromedical Marshaling Point (AMP) at the Air Hub
  - Patients are triaged by medical personnel staffing the AMP at a designated Air Hub and made "flight ready"
  - Patients are transferred to the evacuating aircraft
  - Patients are flown to a receiving Patient Receiving Area at a designated FCC
  - Patients are re-triaged and transported by ground ambulance to an awaiting NDMS participating hospital

- Air Transportation assets will come from the following state and federal sources:
  - Contracted assets through TDEM and DSHS
  - Texas Military Forces
  - Health and Human Services (HHS)
  - Department of Defense (DoD)

- Location of Air Assets:
  - The locations of air medical transportation assets will be determined by the storm path and the availability of suitable airport and landing facilities.
  - TDEM and Federal partners will work together to determine the most appropriate locations for these vital medical transportation resources

d. AIR TRANSPORTATION COMMAND AND CONTROL The Air Coordination Group located at Camp Mabry assists in coordination of all air missions; civilian and military, medical and non-medical.

1) DSHS SMOC will assign an Air Liaison to this Air Coordination Group and this individual will provide the Air Coordination Group with information related to
   - Hospital and Nursing Home evacuation status pulled from WebEOC and EMSystems
   - Available hospital beds
   - Medical transportation requests and potential issues involving the same

I. PATIENT MOVEMENT REQUEST FORM - PMR AND "PATIENT-MISSION MANIFEST"

1. Hospitals and Nursing Homes should report their status to their Emergency Operation Center/ Medical Operations Center (EOC/MOC) as requested by their local emergency management officials. This applies if they will shelter-in-place, evacuate on their own without assistance, or evacuate and require assistance. They should provide their facilities status to the EOC/MOC in the format prescribed by their local emergency management.

2. If the local EOC/MOC determines they require state and/or federal air assets to support their evacuation then the "Patient Movement Request Form" or PMR must be submitted. The PMR form requests basic facility and patient information (including the TexasETN identification number) that provides the patients acuity information. These data elements assist response agencies in identifying the proper assets to properly transport the person based on their medical needs.

3. Submittal of the PMR

   a. Submittal of the PMR should follow the process described in Attachment 7- Patient Movement Request Form – PMR – 14 STEP FLOW PROCESS.

   b. If a facility requests support for evacuation of MEDICAL POPULATION people it must be reported to the appropriate EOC/MOC first.

   c. If the EOC/MOC recognizes that the local jurisdiction lacks the medical transportation resources to adequately support the requests to evacuate a facility utilizing ground transportation assets they must notify the DDC.

   d. If the DDC determines that they do not have the resources to support the evacuation assignment utilizing ground transportation assets they will notify the SOC and the DSHS SMOC.

   e. Ground transportation assets, small fixed wing and rotor wing air assets will be utilized as the primary mechanism to move MEDICAL POPULATION people. If these assets cannot meet the demands then the large assets of TxMF and NDMS will be utilized.

   f. For DSHS, Texas Military Forces, and NDMS to properly process any requests for large scale air transportation they must have the patient information that is found on Patient Movement Request Form – PMR. Either the evacuating hospital or the local EOC/MOC must file the PMR and provide it to the appropriate Medical Operation Center (CMOC or RMOC). The M-IST can assist in this process. If the patients on the PMR are going to be airlifted from a region then the Division MOC will forward the patient information on the PMR to the DSHS SMOC. The PMR can be submitted to the SMOC as follows:
      - e-mailed to: dshsoperations@dshs.state.tx.us or
      - Faxed to 512-776-4980

      NOTE: Because of the sensitive nature of data on this form it **cannot** be sent to DSHS utilizing WebEOC.

g. At the SMOC the Operations Group and the GPMRC will receive and process the PMR From 1 and development of the air “Mission Assignment” that activates the large air transportation assets.

h. After the PMR’s has been processed the GPMRC will build the "Patient-Mission Manifest" and this will be forwarded back to the local EOC/MOC and evacuating facilities by reversing the established points of contact.

J. TEXAS MILITARY FORCES AND NDMS AIR EVACUATION

Large scale Air Evacuation (AE) operations are provided by the resources and personnel from the Texas Military Forces (state) and/or the National Disaster Medical System - NDMS (federal). Note: Medical professionals and emergency management leaders need to understand that the flight on a military type aircraft (C-17 and C-130) is very harsh to a MEDICAL POPULATION person. A community should view NDMS and Texas Military Forces Air evacuation operations as a “last resort” step in their evacuation process. Military type air assets are utilized primarily because all other efforts and systems in place have not met the demand for evacuation capacity.

Because a state disaster declaration usually is given before a Presidential disaster declaration, Texas Military Forces (state) air evacuation operations usually are initiated before Federal NDMS operations. Once a Presidential disaster declaration is received then federal air assets are activated and NDMS operations can be initiated. Both NDMS and TxMF operations can function simultaneously at an Air Hub.

For both state and federal air operations, people with medical needs are received at the Aeromedical Marshalling Point (AMP) at a designated Air Hub where they are processed, triaged, prepared and made “flight-ready”, transferred to an aircraft, and evacuated to receiving location. Note: Any patient that cannot be made “flight-ready” will be transported to an acceptable facility with shelter-in-place capability OR evacuated by ground asset, or other appropriate air asset. At the receiving sites (For NDMS flights they will be transported to a Federal Coordinating Centers - FCC), the people with medical needs are “triaged”, provide necessary medical care, and then transported to an appropriate medical facility based on their current medical conditions.
Whether a person is evacuated on a state air asset by Texas Military Forces (a non-NDMS evacuee) or a federal asset by NDMS (an “official” NDMS evacuee) the PMR and the “Patient-Mission Manifest” shall be utilized to coordinate and document all air evacuee transfers.

K. COMMAND AND CONTROL OF AIR HUB OPERATIONS

The State Operating Center and the DSHS SMOC will closely monitor a storms path and the potential impact to a region. If Air Operations are anticipated Texas Military Forces and NDMS will be notified and assets will be “pre-stage” at designated Air Hubs in anticipation of air evacuation. The following is a general overview of how these Air Hubs will function:

1. Command and Control

   a. Air Hub operations are performed under a Unified Command System.

b. **Local jurisdictions are requested to provide the Incident Commander!**

c. A state "Incident Management Team" (IMT) can be requested to assist in overall coordination of Air Hub operations.

2. Patient care at the Air Hubs will be provided by

a. Local medical providers.

b. NDMS medical support teams (MASF/DMAT Strike Team) can provide limited patient care if an Aeromedical Marshaling Points (AMP) is located at the designated Air Hub. The primary objective of the MASF is to package patients and make them "air ready" prior to the patients being loaded on the designated aircraft. Note – the DMAT Strike Team's primary role is to provide workforce protection for the air operations crew and is not specifically assigned to patient care element.

c. Texas Military Forces medical staff.

3. Patient Care on the air evacuation asset will be provided by

a. NDMS - The Aeromedical Evacuation (AE) crewmembers.

b. Texas Military Forces will provide medical support teams for their air assets.

Note: One hospital staff member or family member can travel with patients on NDMS flights, but may not provide in-flight medical care. This request to accompany the patient must be noted on PMR.

4. If requested and available, DoD will assign Critical Care Air Transport Teams (CCATT) to manage those patients needing critical care support.

a. Each CCATT is comprised of an intensivist, a critical care nurse and a respiratory technician.

b. One CCATT can manage 6 critical patients.

c. There are VERY limited numbers of CCATTs, which limits the number of critical patients NDMS can be moved utilizing DoD aircraft.

L. RECOMMENDED PATIENTS

1. In general, NDMS aircraft or Texas Military Forces aircraft should be utilized for the evacuation of community-based, low acuity medical citizens. Even though NDMS has Critical Care Air Transport Teams (CCATT) that provide the capability to move critical care patients – those patients who are electrically or ventilator dependant or require intensive care – the process ties up significant resources which can impact the final outcome of the number of people that can be transported. In order to maximize the capability of DoD aircraft and transport the greatest number of medical patients it is recommended that critical care patients be evacuated by ground or small fixed wing and rotor-wing assets.

2. Following this guideline maximizes patient throughput and ensures the appropriate standard of care is maintained.

3. Federal NDSM & TxMF Transfer activities:

   a. Regions requesting support to evacuate patients utilizing state and federal assistance must complete and submit the PMR. The Medical Incident Support Team will distribute this form to all appropriate EOC/MOCs during a large scale evacuation.

   b. Air operations from a designated Air Hub will be managed in a Unified Command ICS format under the authority of local emergency management and the airport manager and supported by NDMS and Texas Military Forces staff.

   c. The Air Hub Unified Command will assure that:

      1) All air transportation assets are assembled and ready to begin transportation of patients utilizing air assets.

      2) The PMR submitted by the facility has been processed through the established steps and the evacuation "Patient-Mission Manifest" has been published (Shared with the appropriate EOC/MOC and medical facility evacuation team).
      Note: The "Patient-Mission Manifest" identifies the aircraft tail number, arrival time, and patients to be loaded on each aircraft. This helps determine the time when these patients should be transferred from a healthcare facility to the AMP.

      3) NDMS assets are located at the Air Hub and the Global Patient Movement Requirements Center (GPMRC) has processed the PMR and provided the "Patient-Mission Manifest" for NDMS assets to begin patient transfers.

      4) Texas Military Forces assets are located at the designated Air Hub and have been provided a "Patient-Mission Manifest" of Medical patients that require Texas Military Forces air medical transportation assets.

      5) Other rotor wing and fixed wing transportation assets have been assembled and are prepared to begin transfer of patients to designated facilities or reception points and these transfers are coordinated through the local EOCs of the evacuating and receiving facilities.

   d. **Movement of Patients to the Air Hubs**

      1) The movement of patients to the Air Hubs must be carefully coordinated.

      2) Communications links between the NDMS and Texas Military Forces commanders, the local EOC/MOC and the evacuating MEDICAL POPULATION facilities must be established by the Unified Command Team in order to effectively and efficiently transfer patients from facilities to Air Hubs. The Medical Incident Support Teams (M-IST) and the medical professionals supporting the ESF-8 response will assist in coordination of this process.

      3) It can take up to 2 hours for the evacuation teams at the Air Hubs (Aeromedical Evacuation - AE Team) to receive, prepare and load patients

onto NDMS aircraft. In order to reduce the strain on patients it is imperative that there be very well coordinated patient movement in these Air Hub operations so patients are not staged on the airfield longer than 2 hours.

a) Local EMS and the AHATT begin the movement of patients to the Air Hubs at the designated times provided by NDMS or Texas Military Forces as outlined in the "mission assignments". This information will be provided to the medical facilities.

b) The physical efforts to move large numbers of patients off of an ambulance, around the medical staging area for triage and packaging, and onto the air asset requires a significant amount of personnel. Note: Local jurisdictions should plan for a process of calling in previously identified teams of personnel to assist in the performance of this task.

c) Local emergency management officials should make preparations to provide "litter bearers" to support the movement of patients on and around the Air Hub and on to the air assets. This is a very labor intensive process and strong physically fit persons are needed for this task.

M. ARRIVAL AND OFF LOAD

Texas Military Forces will evacuate patients to designated locations based on the storms impact. NDMS will evacuate patients to two primary locations: Dallas/Ft. Worth and El Paso. Local jurisdictions will have to provide support and coordination to the arrival and "off loading" of patients from the planes.

1. **NDMS**
   a. Military personnel and aircraft will transport patients to pre-designated NDMS Federal Coordinating Center (FCC) airports. FCC sites are found in El Paso, Dallas/Ft. Worth, Houston, and San Antonio. Because of its proximity to the coast, Texas will not use Houston as a receiving location. The receiving facilities will be established based on the projected impact region(s), the storms intensity and the total numbers of people with medical needs that may be evacuated.

   b. The FCC Coordinator will ensure that the patient reception area and the Patient Reception Team are ready to receive the aircraft and patients.

   c. The FCC will coordinate patient transportation from the debarkation airport to the designated NDMS participating hospitals through the local EOC/MOC.

   d. The FCCs will track patients from the time they are received at the airport until they are discharged from a healthcare facility in accordance with NDMS guidelines.

2. **Texas Military Forces**
   a. TxMF will coordinate patient movements to receiving airport sites determined by TDEM.

b. Texas Military Forces should coordinate with the DSHS SMOC to obtain medical support personnel and supplies to augment existing resources at the embarkation and debarkation airport sites.

c. In flight care will be provided by TxMF medical personnel and support staff as needed.

d. Receiving airports must be prepared to provide medical assistance to:

1) Off load patients.

2) Triage patients.

3) Transport patients to receiving facilities.

N. PATIENT TRACKING

Patient tracking will be coordinated between embarkation points, medical facility, embarkation sites and Air Hubs) and debarkation points (hospitals, general population shelters, medical shelters, and long term care facilities) utilizing the state designated tracking system. The following tracking systems are utilized:

1. State "Texas Emergency Tracking Network"- (Texas ETN). This is the States of Texas designated medical patient and evacuee tracking tool.

2. WebEOC – Available in most regions across the state. Contact your local Emergency Management Coordinator or your WebEOC Administrator for access into the WebEOC system in your region.

3. EMSystems-EMTrack – utilized in the Houston, Panhandle and Lower Rio Grande Valley.

4. Beaumont Tracking System

Note: These systems are integrated and share common data elements between the systems. Utilization of the designated patient tracking tool will assist ALL supporting agencies in managing the movement of the evacuating population and will also assist in managing the re-entry process.

VI. MAINTENANCE & UPDATE

The Response and Recovery is responsible for maintaining and updating the DSHS Response Operating Guidelines. These are living documents and will be reviewed, updated, and approved on an annual basis or more frequently in response to department policy or procedure changes. Revisions/changes made to the ROG after the Effective Date (March 1) are recorded in the Record of Changes form found on Page 4. Below is the review and update schedule that will be followed:

March – December:	Review and Comment	
January:	Post for Review	
March 1:	Effective Date	

VII. ATTACHMENTS

ATTACHMENT 1 – H-120 TIMELINE

ATTACHMENT 2 – DSHS ESF-8 PUBLIC HEALTH AND MEDICAL RESPONSIBILITIES

ATTACHMENT 3 – DSHS MEDICAL SUPPORT RESPONSE TEAMS

ATTACHMENT 4 – AMBULANCE DEPLOYMENT

ATTACHMENT 5 – MEDICAL EVACUATION TRANSPORTATION GUIDELINES

ATTACHMENT 6 – ESF-8: COMMAND, COMMUNICATION & COORDINATION

ATTACHMENT 7 –PATIENT MOVEMENT REQUEST FORM – PMR

ATTACHMENT 8– PMR FORM FLOW PROCESS

ATTACHMENT 9 – AEROMEDICAL EVACUATION PREPARATION CHECKLIST

ATTACHMENT 10 – NURSING HOME EVACUATIONS

ATTACHMENT 11 – TEXAS 213RR - COPY

ATTACHMENT 1 – H-120 TIMELINE

H-Hour	Activity	Responsibility
H-120	Activate "Call Down" for DSHS Command staff and initial SMOC Teams	DSHS Response and Recovery Unit
	Texas - Notify EMS Ambulance MOA providers of pending situation to confirm availability of EMS assets.	DSHS
	Federal – Advise Contractors and FEMA Acquisition advise ambulance contractors on status.	HHS
	Identify resource needs and communicate with SOC via an **Action Request Form (ARF)** regarding: • Disaster Medical Assistance Team • Disaster Mortuary Teams • Medical Transportation Support –Ambulances and Para Transport, NDMS, et al Provide information to Texas State Operation Center (SOC)	DSHS Planning & Intelligence
	Potential Emergency Management Assistance Compact (EMAC) requests are verified and core language drafted.	DSHS
	Establish state ESF-8 conference call schedule: • SOC • HSR • Division 1 and/or 2 and RAC/MOC	SOC & DSHS
	Alert Regional Advisory Councils (RACs) to contact hospitals (Mental Health and Healthcare) to begin 12-hour reporting cycle of Hospital Available Beds in an Emergency or Disaster (HAvBED) data into the DSHS WebEOC TSA Medical Dashboard.	DSHS, RACs and Hospitals
	Contact RACs to notify medical facility regarding their intended response to the developing emergency based on projected storm intensity: • Shelter-in-place (SIP) – provide SIP form • Evacuation (partial or full) – provide all PMR for report of potential ground and air medical transportation support	DSHS, RACs, and hospitals
	Alert and check status of End Stage Renal Disease (ESRD) network	DSHS/DADS
	RAT placed on alert for possible deployment.	DSHS & HSR
	M-IST place on alert for possible deployment.	DSHS
	Validate medical supplies- jump bags and AED monitors- for ALS buses.	DSHS
	ALS Bus transportation Assist team alerted for deployment to San Antonio Staging.	DSHS

H-Hour	Activity	Responsibility
	Ambulance (Federal and state) & Bus Contractors (state) On Alert	DSHS and Federal IRCT Incident Response Coordination Team - HHS
H-96	• Seek state Declaration • Submit all MIEP Action Request Forms (ARFs)	SOC & DSHS
	Warning Order (Alert) issued for all AMPs (Federal - Aeromedical Marshalling Points or AMPs).	Federal IRCT Incident Response Coordination Team – HHS
	Initiate request for Federal Emergency Management Agency (FEMA) and Emergency Management Assistance Compact (EMAC) ambulances.	DSHS and SOC
	Begin to execute state MOA contracts for ambulances, personnel and supplies. Medical Transportation assets to report to San Antonio ARCC Staging (Division 2).	DSHS (Regulatory)
	Notify and activate designated Medical Incident Support Teams (M-IST) for deployment. Teams report to San Antonio ARCC Staging (Division 2).	DSHS
	Notify and activate designated RAT for deployment to designated location as part of the state Forward Coordinating Element.	DSHS
	After mission briefing deploy M-IST teams into evacuating region to liaison with evacuation region DDC/MOC • Establish the “ESF-8 Incident Support Team”. • ESF-8 Incident Support Team develops coordination and communication processes for evacuation of people with medical needs.	M-IST Team, Evacuation MOC, Division MOC, DSHS
	Prepare to activate nurses, EMTs and Paramedics for evacuation buses. Report to San Antonio ARCC Staging (Division 2).	DSHS (SMOC Logistics and Regulatory)
	Begin evacuation and sheltering coordination to move medical equipment and supplies to Base Staging locations (Division 1 Houston and/or Division 2 San Antonio).	DSHS
	Prepare to deploy NDMS assets for aero-medical evacuation. Medical Transportation assets to report to San Antonio ARCC Staging (Division 2).	DSHS and Federal HHS Incident Response Coordination Team (IRCT)

H-Hour	Activity	Responsibility
	Identify Air Hub locations. Designate Air Hub Incident Commander. Provide designated locations to all partners, local, state and federal.	DDC Region, SOC and DSHS ESF-8
	Provide MOC/RAC with PMR for Hospitals. Provide them with "Just- in-Time-Training" for how to request evacuation assistance See Attachment 7 for flow process. *Note: request for PMR may begin at 84 hours but in no case will it be later than 72 hours.*	Hospitals and RACs, EOCs and DDC SOC (ESF-8 DSHS)-SMOC
	Contact ESRD network for population to be evacuated with ESRD medical issues.	DSHS/DADS
	Verify and activate state and federal personnel assets. Request and Deploy NDMS and FMS personnel and resources to identified locations.	DSHS and IRCT Incident Response Coordination Team - HHS
	Notify Joint Patient Movement Team (JPMT)/Air	IRCT Incident Response Coordination Team - HHS
	Activate contracts for nurses, EMTs, Paramedics for evacuating buses. Must initiate at H-84 for Valley operations.	DSHS (Regulatory)
	DSHS EMS Ambulance Support Team is activated at the Austin DSHS Exchange Building.	DSHS (Regulatory)
H-84	Formally request hospitals provide status report utilizing designated forms: • Shelter-in-Place • Evacuate • Evacuate with Assistance	DSHS though RACs, EOC/MOC
	Deploy Sate and Federal medical transportation assets to Division Base Camp staging areas for evacuation of medical patients.	SOC and DSHS ESF-8 IRCT – HHS, DoD
	State ESF-8 conducts additional conference calls to determine readiness of Air Hubs (Note: Air Hubs must be in place no later than H-72).	DSHS & Federal Partners
	Identify Air Hubs ***activation time***, and deploy personnel to AMP locations within 4-hours.	IRCT Incident Response Coordination Team - HHS
	Evaluate need for Federal Medical Shelter support and request if needed (this includes FMS and/or staffing support and/or medical assets).	SOC & DSHS

H-Hour	Activity	Responsibility
H-84 Continued	RAT and M-IST establishes **ESF-8 Incident Support Team** at the EOC/DDC designated location(s).	DSHS
	ESF-8 Incident Support Team establishes coordinated communication processes for ESF-8 with: • DSHS SMOC • Division 1 and/or 2 • Evacuation MOC • Receiving MOCs • Embarkation Sites and Air Hubs • TxMF & Federal response partners/agencies	DSHS SMOC, M-IST, Division 1 and 2 Regional MOC
	Embarkation Sites, Fuel Sites, Comfort Stations and forward Staging Area designated and set up.	SOC and TxMF
	Pre-stage assets (Division 1 Houston or Division 2 San Antonio staging areas) • Ambulances and ALS Buses (request need to TDEM) • Supplies and Medical Shelter Push Packs • Federal Medical Station (FMS) • Medical personnel (clinicians and coordinators) • Request Rotor Wing and Ambulance aircraft • Para-transit vehicles	SOC, DSHS, Federal Partners
	Request Health Service Regions (HSR) provide the locations of: • Reception centers • Medical Shelters • Long term care facilities /shelters	DSHS & HSR
	Hospitals submit PMR for Ground and Air medical transportation assistance following the 14 Step process listed in Attachment 7. Note: NDMS/GPMRC need enough lead-time to begin patient movement at H-72 hours so PMR must be submitted at H-84.	Hospitals, Evacuation MOC ESF-8 Incident Support Team, Division MOC, DSHS Federal Partners
	For Valley operations- Ambulance Transportation assets notified to begin deployment to evacuation region. PMR must be submitted from LRGV medical facilities beginning at H-84. Note: For Valley Operations Staging location is the Edinburg Airport.	SOC and DSHS
	TDEM and DSHS will make push for commitment from hospitals to declare whether they will evacuate or shelter-in-place.	DSHS
	DSHS issue a request to have all PMR's submitted to the Regional MOC and to the SMOC at the 72-hour time frame.	DSHS
H-72	Continue to monitor status of: • Medical Evacuation • Nursing homes & Assisted living facilities • Hospitals • Transportation of medical patients/people • End Stage Renal Dialysis Network (ESRD)	DSHS/DADS

H-Hour	Activity	Responsibility
H-72 Continued	ESF-8 Incident Support Team coordinates filling out and filing of PMR for ground or air requests for medical transportation support.	DSHS ESF-8 Incident Support Team and M-IST
	Identify number and locations of designated medical shelters. Provide data in Sit Rep report and WebEOC.	DSHS Austin and Health Service Regions (Assisted by BCFS, ARC, MASS Care)
	Deploy Federal Medical Support (FMS) to designated medical shelters locations if required. Begin set up of FMS at identified sites.	IRCT
	ESF-8 Incident Support Team and Evacuation MOC perform status check from hospitals regarding request for evacuation assistance. Communicates information to Division MOC and DSHS SMOC.	ESF-8 Incident Support Team, Evacuation MOC, Division MOC, DSHSIRCT
	Medical Incident Support Team members in place at various operational nodes. M-IST and ASM personnel assigned to designated Air Hubs as part of the Ambulance coordination process.	DSHS Austin Operations M-IST, ASM
	ESF-8 Incident Support Team and Evacuation MOC request update for SIP hospitals that may require augmentation. Note: Current SIP Form must be provided to facility.	ESF-8 Incident Support Team, Evacuation MOC, Division MOC, DSHSESF-8
	Federal Partners • Evacuation Liaison Team (AELT)/Medical Air Staging Facilities (MASF) In Place (NDMS Partners & DoD) • Joint Patient Movement Team (JPMT)/Air in place DoD • NDMS in place and Patient Movement can be initiated DoD • Full Staff At Medical Unified Command Cell (all partners work with ESF-8 Incident Support Team, CMOC, and/or RMOC)	IRCT Incident Response Coordination Team – HHS DoD,
	Prepare to receive people with medical needs at Federal Medical Stations (if required). State and federal contracted ambulances/buses /para-transit vehicles are in their assigned location. • (NOTE: This may be acted upon at H-84 for Valley Operations)	HHS & DSHS
	Hospitals identify/declare SIP and report this to the Evacuation MOC and the ESF-8 Incident Support Team.	Hospitals, Evacuation MOC ESF-8 Incident Support Team, Division MOC, DSHSHHS & DSHS
	Hospitals submit PMR for ground and Air medical transportation assistance. Note: Must be submitted at H-84 for LRGV operations.	Hospitals, Evacuation MOC ESF-8 Incident Support Team, Division MOC, DSHS Federal Partners
	NDMS Air Transports: GPMRC creates NDMS mission assignment. Forwards	GPMRC, DSHS SMOC, Division MOCs, ESF-8

H-Hour	Activity	Responsibility
H-72 Continued	information through designated response process. Note: GPMRC will forward the same information to the receiving FCC.	Incident Support Team, Evacuation Region SOC/MOC, Hospitals
	Confirm placement and availability of federal assets and personnel at all points (Air Hubs and FMS sites). NDMS Air Transports confirmed TxMF Air Assets confirmed	Air Hub Incident Command, EOC, DDC & ESF-8 Incident Support Team, SOC, DoD, TxMF, DSHS
	NDMS/DMAT (5 person Strike Team) will provide oversight and medical assistance to patients at the Air Hub	IRCT- Incident Response Coordination Team, NDMS, Air Hub Incident Command
	At the Air Hub Federal ESF-8 partners are all in place (DMAT/DoD) and prepared to begin receiving patients from hospitals.	ESF-8 Incident Support Team, Evacuation MOC and hospitals, Air Hub Incident Command, EMS-AHATT
	Note: for Valley operations Ground Ops call patients forward for air evacuation no later than H-72. For all other coastal areas evacuation start times will be determined by local officials and facility management, but in no case later than H-60 hours.	Hospitals, Evacuation MOC ESF-8 Incident Support Team, Division MOC, DSHS
	Confirmation of packaging of patients; hospitals begin to prepare patients for forward movement to Air Hubs.	ESF-8 Incident Support Team & M-IST, DoD, TxMF
	Local EMS system (augmented by state and federal medical transportation assets) begin moving patients to Air Hubs utilizing the established Air Hub Ambulance Transportation Team - AHATT.	Evacuation MOC and ESF-8 Incident Support Team Division 1 and 2 MOC
	State and federal assets begin movement of people with medical needs from medical facilities and embarkation sites. **NOTE: hospital patient transfers are coordinated through the evacuation MOC, Division MOC, and receiving MOCs using EMSystems.**	Evacuation MOC, ESF-8 Incident Support Team, Division 1 and 2 MOC
	First evacuees leaves the Air Hub and Embarkation Points.	State and federal ESF-8
	Begin Reception of Patients at designated sites.	State and federal partners
H-66	Evacuation MOC and ESF-8 Incident Support Team continue coordinate transportation missions and Patient Tracking for Ground and Air medical transports.	Evacuation MOC, ESF-8 Incident Support Team, Division MOC, Receiving MOCs
	Ground Ops for Air Transportation– AHATT continues patient pick-up and movement to Air Hub for air evacuation.	Local EMS-AHATT, Evacuation MOC, ESF-8 Incident Support Team, Division MOC

H-60 to H-54	Hospitals/ and the Evacuation EOC/MOC and Division MOC • monitor and report Medical Institution support needs to EOC/DDC/SOC; • provide support for movement of people with medical needs to SIP facilities or out of region.	SOC, ESF-8 DSHS SMOC
	Re-assess operations to confirm placement and availability of state and federal assets and personnel at all points.	Ground Operations and EMS-AHATT & Dispatch
H-54 to H24	Patients continue to move: • Evacuation facilities to receiving facilities/hub cites • Hospitals to Air Hubs for transport to FCC • Embarkation points to receiving sites.	State and federal ESF-8
	• Keep Evacuation & Shelter Information Updated Through JIC • Provide Medical Needs Report • Coordinate Health & Sanitary Need Of Shelters • Continue To Operate Medical Shelters • Continue To Monitor Bed Census • Monitor the Evacuation & Shelter Of Persons Having Mobility Limitations, Including Persons In Nursing Homes, Hospitals, Group Homes & Non-Institutionalized Persons • Provide Rapid Intervention Team for quick response to emergency transfers	State and federal ESF-8
H-48	Continue Ground and Air (NDMS) Patient Evacuation Finalize preparations for Shelter-in-Place activities.	DSHS & Federal partners
H-54 to H24	• Continue To Provide Medical Needs Report • Continue To Coordinate Health & Sanitary Need Of Shelters • Continue To Support Operation Of Medical Shelters • Continue To Monitor Bed Census • Continue To Monitor The Evacuation & Shelter Of population with medical needs Including Persons In Nursing Homes, Hospitals, Group Homes & Non-Institutionalized Persons • H-48 Rapid Assessment Team - RAT deployment to expected landfall area. CAT One placed on alert for possible deployment.	IRCT - Incident Response Coordination Team SOC and DSHS
	Begin planning phase to remove/shelter response assets and personnel.	Local, Regional, and state Incident Command
	State ESF-8 conference call held to determine how many patients are still requiring evacuation and determine when operations will shut down in anticipation of tropical force winds making landfall.	DSHS, Federal Partners, ESF-8 Incident Support Team, Evacuation MOC, hospitals
	State ESF-8 conference call held to determine how many patients are still requiring evacuation and determine when operations will shut down in anticipation of tropical force winds making landfall.	DSHS, Federal Partners, ESF-8 Incident Support Team, Evacuation MOC, hospitals

H-Hour	Activity	Responsibility
H-40	Determine final patient evacuation transports; initiate plans to shelter-in-place (Note: Air Operations end at H-18).	**SOC**, Federal Partners, DSHS ESF-8, DDC, Local Incident Command, Evacuation MOC, ESF-8 Incident Support team
	Ground OPS-monitors dispatch plans for completion within timeframe to discontinue ground evacuation transports.	EOC/DDC, Evacuation MOC, ESF-8 Incident Support Team
	ESF-8 Incident Support Team and USAR establish communication link up and begin planning for pre-storm SAR and begin plans for post strike activities. *Note: must determine safe location for Shelter-in-Place for ESF-8 and ESF-9.*	ESF-8 and ESF-9
	1. Continue To Provide Medical Support. 2. Notify SAR of SMART locations.	Local EMS, Evacuation MOC, ESF-8 Incident Support Team
H-36	**Contra Flow Begins!** **Ground Transportation Assets must be in Place** **Only Air Transportation Assets can re-enter**	SOC
H-36	Deploy Ambulances to shelter clusters following evacuation. Note: Remaining state and federal transportation assets may be pulled out of impact region. Time frame for removal will be determined based in incident factors.	EOC/DDC & DSHS
	Planning for Post-storm needs initiated and evaluated. Coordinate with state FCE Team (DSHS RAT and M-IST).	SOC, ESF-8, DSHS SMOC
H-30	Notify HSRs and RACs of potential deployment of assets for emergency health care support to impacted region.	DSHS SMOC
H-24	Confirm status of hospital evacuations and final shelter–in-place population and determine frequency of reporting.	SOC ESF-8, DSHS SMOC
	Command Assistance Team - CAT 1 pre-staged and ready to deploy to support RAT post landfall. Another CAT put on alert to deploy to affected regional ROC if needed.	DSHS Austin and HSR's
	Confirm Status of Nursing Home evacuations and final shelter-in-place population and determine frequency of reporting.	SOC ESF-8, DSHS and DADS
	Air Hubs are demobilized and conduct a close out report via phone to the RAC/Regional MOC, DDC and state ESF-8.	SOC & ESF-8 DSHS SMOC
	Evacuation City/County EOC, MOC, and ESF-8 Support agencies incorporate shelter-in-place plans	Evacuation MOC, SOC & ESF-8, DSHS SMOC
H-20	Update status of nursing home evacuations and final shelter-in-place population and determine frequency of reporting	SOC ESF-8, DSHS and DADS

H-Hour	Activity	Responsibility
H-18	Demobilization of Operations at Air Hubs.	Air Hub Incident Commander
	Patient Movement Operations for ground and air end.	RAC/Regional MOCs, County EOCs, State ESF-8
	Medical support personnel evacuated/sheltered for storm. Note ALL "contract" assets will be removed from the theater at H-12 Patient Movement Operations for ground and air end.	ESF-8 partners RAC/Regional MOCs, County EOCs, State ESF-8
	Hospitals and Nursing Homes submit listing of Patients, Staff, and Guests for potential rescue post-storm. Finalized SIP Forms submitted to Evacuation MOC, ESF-8 Incident Support Team, Division MOCs, DSHS SMOC. **Forms distributed to Search and Rescue (SAR) -Texas Task Force 1.**	EOC/DDC/SOC ESF-8 DSHS and DADSESF-8 partners
	Evacuation MOC to finalize SIP and SMART location listing for ESF-8.	Federal and State ESF-8
H-12	Update status of nursing home evacuations and final shelter-in-place population.	DSHS and DADS
	Based on final impact location, begin identification of actual risks and impacts to communities and healthcare infrastructure.	SOC, DSHS and Federal Partners
H-12 to H-0 Hours	Evacuation MOC to finalize SIP and SMART location listing for ESF-8.	Federal and State ESF-8
	Begin community assessments for sanitation, facility inspection, issues affecting repatriation, etc., in impacted areas such as: • Condition of medical support infrastructure to provide for Medical Patients/population return • Acute care medical support • Durable Medical Equipment (DME) support • Nursing home support • 911/emergency room support	DSHS & DADS
H-6	**Integration of ESF-8 and ESF-9 activities begins.**	DSHS and USAR
H-0	Begin community assessments based on reports from MOCs and HSR for: sanitation, facility inspection, issues affecting repatriation, etc., in impacted areas such as: • Condition of medical support infrastructure to provide for Medical Patients/population return • Acute care medical support • Durable Medical Equipment (DME) support • Nursing home support • 911/emergency room support	DSHS, Division MOCs, ESF-8 Incident Support Team
Re-Entry	Establish communications with hospitals to establish status of capability.	Local EOC/MOC DDC, ESF-8, M-IST

H-Hour	Activity	Responsibility
Phase R = 0	Determine access avenues for approach and departures routes for medical transportation assets.	SOC, Federal Partners, TxMF, USAR
	Establish Emergency Health Care. • Assess local emergency health care capability • Activate regional mobile medical assets as required • Assess need for potential deployment of DMAT	DSHS, DDC, EOC Local EOC/DDC
	Determine/Assess potential deployment for Disaster Medical Assistance Team.	SOC and Federal Partners
	Work with SAR/TxTF-1 to establish medical "pick up" evacuation points for people with medical needs. Search and Rescue • Reconvene patient evacuation • Establish triage and treatment point • Medically support Search and Rescue (SAR) • Provide medical logistics support • Determine/Assess potential deployment for Disaster Medical Assistance Team	Evacuation MOC, ESF-9 TxTF-1, ESF-8 Incident Support team EOC/DDC SOC -DSHS SOC and Federal Partners
	Determine Status of local EMS transportation assets and capabilities. Augment with state and federal transportation assets as necessary.	Local EOC, DDC, Evacuation MOCs ESF-8 Incident Support Team
	Establish communication with FEMA, DDCs, CDC, DSHS and regional and local public health established in the field.	SOC/DSHS and Federal Partners ESF-8 Incident Support Team STAE FCE, DSHS RAT CAT & M-IST
	Initiate communications and begin damage assessment for hospitals and long-term care facilities.	DSHS & DADS
	Organize communications between response agencies. Establish points of contacts, locations, and capabilities for ERs, Hospitals, DMAT, etc. If standard telecom unavailable establish redundant communications.	Evacuation EOC/DDC, Evacuation MOC, ESF-8 Incident Support Team Local, state and federal ESF-8 partners
R + 6	Determine emergency room and DMAT team contacts and set up data collection system at emergency care points.	SOC/DSHS and Federal Partners
	Complete initial community/regulatory assessments and allow cleared facilities to re-open.	Local Emergency Management, DSHS
R + 24	Disaster Mental Health: Apply for Substance Abuse and Mental Health Services Administration (SAMHSA) grant – time sensitive.	DSHS

H-Hour	Activity	Responsibility
R + 48	Continue to support all ESF-8 related activities: SAR, Patient Evacuation, Shelters, PODS, CISM, vector control, etc.	Federal, state and local health agencies
R + 72	Continue to support all ESF-8 related activities: SAR, Patient Evacuation, Shelters, PODS, CISM, vector control, etc.	Federal, state and local health agencies

Definitions:

- H-Hour is the time of projected onset of tropical force winds striking the coast of Texas.
- "R" The "Re-Entry Phase" is initiated as soon as possible after the event has occurred. There is an unknown period of time between H-hour and R-hour during which the hurricane will have made landfall and begins moving inland. In a hurricane this occurs after tropical storm force winds have subsided. This is the time when conditions allow for the Texas Re-Entry Task Forces to enter into the impact zone or evacuation zones.

ATTACHMENT 2 - ESF-8 PUBLIC HEALTH AND MEDICAL RESPONSIBILITIES

The Texas Department of State Health Services (DSHS) is responsible for ESF 8 activities within the State of Texas. DSHS coordinates all state-level medical, public health and mental health support activities during large-scale emergencies. In large-scale evacuations DSHS has the following responsibilities as the state ESF 8 lead agency:

1. Coordinates resources with and between medical institutions, EMS, and other critical healthcare operations and functions. Provides medical surveillance and patient tracking.

2. Coordinates medical shelters support with Department of Aging and Disability Services (DADS), Department of Assistive and Rehabilitative Services (DARS), and the DSHS Health Service Regions (HSR).

3. Notify HHS Region VI Regional Emergency Coordinator of possible evacuation of medical facilities.

5. Coordinate evacuation needs and progress with SOC.

6. Request assets and assistance from other ESF functions in the SOC.

7. Coordinate medical care for Medical Shelters and general population shelters.

8. Report on ESF 8 issues through situation reports (SIT/REP) to SOC.

9. Forward medical SIT/REPs to Federal ESF 8 partners.

10. The ESF 8 desk at the SOC along with the DSHS SMOC.

    a. Tracks all ground medical transportation assets.
    b. Requests Federal medical transportation assets.
    c. Credentials and placards medical transportation assets.
    d. Provides Medical Incident Support Team to assist the local EOC with the coordination of state assets provided to support local evacuation efforts at the local Ambulance Deployment Coordination Centers.
    e. Provides a liaison to the state and federal command centers.

ATTACHMENT 3 – DSHS MEDICAL SUPPORT RESPONSE TEAMS

The purpose of Attachment 3 is to provide a descriptive overview of the types of teams that may be utilized during a large-scale evacuation of multiple coastal healthcare facilities and people with medical needs. In addition, the document provides the composition of the team, the activities and general missions associated with each of the teams. Terms used by DSHS may not be the same as terminology used by local responders.

I. Facility Evacuation Team

The Facility Evacuation Team refers to the staff within the facility that has responsibility for safe evacuation of the patients/residents within the facility. They are required to promulgate PMR- "Request for Evacuation Assistance" and the Patient-Mission Manifest, triage patients utilizing the criteria within this document, initiate the movement of patients to waiting transportation assets and assist in the loading of patients, and in some cases travel with and provide care to patients being transported.

A. Team Make Up

1. Facility Patient Load Officer (Required for each facility)

    a) Meets with Local Evacuation Strike Team "Transport Officer".

    b) Meets with the Ambulance Strike Team Leader to coordinate patient loading and transportation.

    c) May meet with a Medical Incident Support Team (M-IST) member to coordinated large-scale movements and Air Hub operations.

2. Staff that must travel with patient.

3. Triage Team – must coordinate with.

    a) Ambulance Strike Teams Leaders.

    b) Medical Incident Support Team (M-IST) members to coordinated large-scale movements and Air Hub operations.

    c) Load Team

B. Team Activities/Objectives

1. The facility must have an "evacuation plan"

2. Responsible for notification of:

    a. Facility Evacuation Team members.

    b. Local Evacuation Partners – first responders (9-1-1, EMS, Fire, Police, Public Health).

    c. Local Emergency Management.

3. Provide patient data to EOC/MOC: names, acuities, etc., utilizing designated PMR forms or format.

4. Provide staff and medical equipment and assets for transfer, and coordinates movement with assisting Local Evacuation Partners - first responders (9-1-1, EMS, Fire, Police, Public Health).

5. Must have ability to communicate with the Facility Evacuation Team, local Movement Control Team (led by Emergency Medical Services-EMS, and Emergency Management-EOC, Note: may be assisted by Regional Advisory Council-RAC, MOC and/or Medical Incident Support Team).

    a. Phone, Fax, Radio

    b. EMSystem, EMResource, WebEOC, etc.

6. Must utilize “patient tracking system” during evacuation.

Medical Incident Support Team (M-IST)

The Medical Incident Support Teams (M-IST) members assist in establishing the coordination and communication of all ESF-8 activities between all of the responding support agencies. The M-IST assists in coordinating the integration of state and federal assets into a regions overall evacuation objectives. The M-IST helps to establish the ESF-8 Incident Support Team located in the DDC and provides the point of contact for local emergency management to access state and federal resources. The Medical Incident Support Team will work with the DDC Captain to determine the optimum location for the ESF-8 Incident Support Team to conduct health and medical activities. Once established, this team will provide the conduit for communication links between all response agencies.

A. The mission of the Medical Incident Support Team (M-IST)

1. **Objective 1: Assist in Health and Medical Response Activities.** The M-IST will respond to a region that requires assistance in an evacuation effort, make contact with the DDC and the regional evacuation support agencies, and provide support as requested to the region’s medical response efforts. This involves establishing communication processes with the region’s emergency response agencies and advising them of the assets and support that is being made available from the state/federal response efforts. Although the bulk of their efforts will center on coordination of the evacuation of MEDICAL POPULATION people, there may be other taskings performed as determined by the DDC or local incident command.

2. **Objective 2: Destination Determination, Patient Tracking, and Notifications. The M-IST will work with the evacuating region’s EOC and DDC and the receiving EOC and DDC to support health and medical (ESF-8) activities. Some of the activities that the M-IST will perform include:**

    a. Work with local officials to coordinate requests for medical transportation assets.

b. Work with local officials to identify and establish suitable ambulance staging areas.

c. Work with the local EMS Ambulance Dispatching Centers to coordinate ambulance deployments to evacuating facilities.

d. Assist in the coordination of patient transport activity.

e. Provide the necessary medical population evacuation information to the receiving regions/cities. This information will provide receiving communities with the data necessary to make proper preparations at their reception centers and medical facilities. The Medical Incident Support Team's ability to provide specificity of patient information (both in volume and acuity) to receiving cites will allow for better management of the incoming patients and better patient care during the evacuation process.

B. Additional detail on the mission of the Medical Incident Support Team (M-IST)

Once deployed the M-IST will make contact with the DDC (or if not operational - the requesting counties' EOCs) and perform any or all of the following objectives.

1. Establish contact and communication processes with requesting region's Incident Command Structure

   a. DDCs

      1) Health Service Region (HSR).

      2) RLOs.

   b. Local EOC/Incident Command.

      Establish the communication links into the local EMS structure to facilitate the deployment of any incoming "Ambulance Strike Teams" or individual units upon request from the evacuating region's EOC/MOC.

   c. Work with the TDEM Forward Coordinating Element, the DDC, and the EOC to establish the location of the ESF-8 Incident Support Team and begin the process of establishing communication links with various agencies and response partners.

2. Assist in identifying proper locations for Ambulance Staging and Rehab Areas. Provide information to DDCs, SOC/DSHS SMOC and receiving Division Medical Operation Centers (MOC).

   a. Assist as necessary in staging of Ambulances Strike Teams.

   b. Assess and identify phone numbers and/or radio compatibility with support agencies and responders.

c. Establish necessary communication links with evacuating facilities. Establish points of contact & phone number with either the respective EOC or MOC or facility(s) as necessary.

3. Identify/confirm locations of **Embarkation Points**. Provide information to SOC/DSHS SMOC, DDCs, and Division Medical Operation Centers.

    a. Locations.

    b. Points of Contact (TxMF staff).

    c. Phone numbers and/or radio compatibility.

4. Identify/confirm locations of Air Hubs. Provide information to SOC, DSHS SMOC and receiving DDCs, and regional MOCs.

    a. Locations.

    b. Points of Contact (command staff for TxMF, NDMS, MASF).

    c. Phone numbers and/or radio compatibility.

5. Identify location of and establish contact and coordination with the Air Hub IC.

    a. TxMF command staff.

    b. NDMS command staff.

    c. MASF command staff.

    d. Local EMS and the Air Hub Ambulance Transportation Team.

6. Provide support to Urban Search and Rescue efforts (USAR)

    a. Provide for Ambulance support.

    b. Provide “Patient Tracking” documentation.

    c. Provide communication of patient transports for USAR to receiving locations: hospitals, embarkation hubs, etc.

Ambulance Strike Teams

A configuration of ambulances leads by an Ambulance Strike Team Leader with common communication capability that responds to major medical events. These teams can be assembled and deployed by three methods:

- Medical units brought into an event by activation of a regionally established response plan.

- Medical units brought into a major response utilizing state contracted ambulance providers.

- Federal Medical Units pulled together by combining medical units provide by FEMA and organized into Ambulance Strike Teams when they arrive in Staging in San Antonio or Houston.

Note: If Medical Units have been deployed into a region and they arrive as single resources, they will be assembled into Strike Teams to facilitate proper command and control of these vital assets. This can occur by local Incident Command or be handled with the assistance of a Medical Incident Support Team.

A. Ambulance Strike Team Make-Up

1. 5 to 7 Type III Ambulances with staffing.

2. Minimum two person crew; EMT and EMT-P or 2 EMT-P per ambulance.

3. Ambulance Strike Team Leader with transportation vehicle.

4. Common communication between designated team assets.

    a. Radio

    b. Cellular phone

B. Team Purpose

1. Ambulance Strike Teams will respond to mission assignments and perform as directed. They may be assigned to support the following evacuation locations:
    a. Evacuating region EMS Response System.

    b. Specific Hospital Evacuation missions.

    c. Specific Nursing Home Evacuation missions.

    d. Embarkation Support.

    e. Shelter Support.

    f. POD Support.

    g. Air Hub Ambulance Transportation Teams (AHATT).

    h. Other missions as assigned.

2. Ambulance Strike Team personnel are required to perform the following tasks:
    a. Proper triage to assist in matching the patients to the most appropriate transportation asset.

    b. Capability to communicate with their Strike Team Leader, Medical Incident Support Team, ESF-8 Incident Support Team.

c. Capability to coordinate activities with local EMS Ambulance Units and local EMS Dispatch Centers.

d. Communication of location and availability at all times.

e. Notification of completion of mission assignments.

3. Ambulance Strike Team Leader – an EMS supervisor suitably trained and qualified to effectively manage and direct a strike team of ambulances to effectively respond to a major medical event.

Air Hub Ambulance Transportation Team (AHATT)

Requirements for transport to and activities at airport Air Hubs. Note: The following activities are to be coordinated with local emergency response efforts. The AHATT can request additional support for medical transportation assets by contacting the regional staging area for medical assets. This will be coordinated through the designated Ambulance Deployment Coordination Center (Local EMS Dispatch).

Airport Hub Ambulance Transportation Team (AHATT) Responsibilities include:

1. Coordinate with Airport IC.

   a. Access to Airport Operations area (AE).

   b. Transportation Security Agency.

   c. Customs & Border Patrol.

2. Coordinate with NDMS (Air Force MASF Lead) for flight manifest.

3. Coordinate and communicate with TxMF.

4. Manage hospital to airport patient movement based on flight manifest. **Move patients from hospital to airport on military liters. In order to make military liters available these must be requested before patient load operations occur at the hospitals.**

5. Determine EMS asset needs based on planes available and patients to be evacuated.

6. Establish routes and control route flow.

7. Evaluate manifest to establish order of patient movement (least acute first, most acute last).

8. Interface with hospitals “load officer” (person in charge of evacuation process).

ATTACHMENT 4 – AMBULANCE DEPLOYMENT

Medical transportation assets such as ambulances are one of the most limited resources available in a major disaster. Local medical response agencies and all supporting response partners must establish a strong command, communication and coordination element to provide proper management of this critical resource. In addition to this "3C" approach, the triage criteria provided in this document must be utilized to match all medical patients/population with the most appropriate transportation asset. Note: See the Department of State Health Services ***Response Operating Guideline - Ambulance Utilization 2011*** for specific details on the recommended policies and procedures for ambulance usage during a disaster.

The local EOC and the regional DDC should have a medical operations center as a component of a response to an emergency or disaster. This Medical Operation Center (MOC) is the coordinating element for all ambulance management, deployment, and patient tracking that occurs during a response. This MOC, whether it is at the City/County EOC or the regional DDC, is the point of interaction for all support agencies that are assisting with health and medical response. All questions related to ambulance requests, deployments and dispatches in a region must be coordinated through these Medical Operation Centers.

A The MOC is represented by medical professionals from:

1. EMS, *(Note: Local EMS is one of the prime agencies that will be represented in the local City/County MOC)*
2. Hospitals representatives.
3. Local Public Health.
4. Regional Advisory Councils .
5. DSHS teams: RAT, CAT, DOG.
6. Health Service Region.
7. Other medical support agencies.

a. Support from the local Medical Operation Center.

b. Support from deployed Medical Incident Support Team members.

c. Command and Control from the evacuation DDC.

d. Coordination between the evacuation DDC and the appropriate Division 1 or Division 2 Staging Area MOC (Houston-CMOC or San Antonio-RMOC).

B. Activities of the MOC related to ambulances includes:

4. Collection of the following information from each hospital and nursing home:

a. Patient Movement Request (PMR) forms: request for state and federal evacuation assistance.

b. Private Patient Movement Report (Hospital closures).

c. Shelter-in-Place (SIP) information.

5. Provide a medical transportation needs request to the EOC → DDC → SOC → DSHS SMOC so that gaps in resource requirements can be addressed.

6. Receive hospital information for patient and resource tracking.

7. Forward all medical evacuation information to regional DDC ESF-8 MOC and the DSHS SMOC.

8. Establish contact information and working relations with the evacuating healthcare facilities' load officers. Provide triage criteria information to the healthcare facility Patient Load Officer that will help identify evacuating populations for:
   a. Ambulances.

   b. ALS Buses.

   c. "Litter" buses.

   d. Para-transit and Ambulette vehicles.

   e. Air transportation (National Disaster Medical System – NDMS, TxMF, Air Ambulances).

9. Coordinate evacuation of people with medical needs from hospital, nursing homes, and home health environments.

10. Dispatch transportation assets to retrieve the patients from hospitals, nursing homes and home health environments.

11. Compile and forward all requests for Air Evacuation to the DSHS SMOC so that Texas Military Forces and NDMS can process the request and develop the appropriate "mission assignments" to their response teams

12. Coordinate ambulance resources.

    a. Direct receiving and dispatch activities at ambulance staging area.

    b. Provide for ambulance crew needs and equipment re-stock as needed.

    c. Identify and/or assure formation of ambulance strike teams.

    d. Provide command and control support for deployment of units to evacuation mission.

e. Ensure all units and crews are either dispatched out of evacuation zone, or are sheltered safely during event (hurricane landfall).

f. Assist with appropriate demobilization.

13. Provide guidance to evacuation regions on the utilization of the Texas Emergency Tracking Network (Texas ETN), EMTrack, WebEOC, as appropriate, to enable officials to the ability to track the movement of their medical population.

14. Establish methods of transportation for medical evacuees from evacuating facility to the Air Hub-Aeromedical Marshalling Point (AMP) Medical Assistance Staging Facility (MASF).

15. Coordinate with the state ESF-8 Incident Support Teams to assist in filling unmet needs in transportation requirements for:

    a. Facility-to-facility transfers - (for both local and/or out of region)

    b. Facility to embarkation sites

    c. Embarkation sites to receiving destinations.

    d. Facility-to-Air Hubs - establish contact with coordination team

16. Coordinate with the Texas Military Forces (TxMF) for:

    a. Embarkation Point activities

    b. Receiving sites activities

    c. Air Hub activities

17. Assist in the coordination of the Air Hub Ambulance Transportation Team (AHATT) Healthcare facilities to airfield Air Hub or Aeromedical Marshaling Point (AMP).

    a. Establish contact with Air/Ground coordination team (TxMF, MASF)

    b. Identify evacuating populations requiring special medical equipment such as ventilators, intra-aortic balloon pumps, ventricular assist devices, trans-venous pacing, etc.

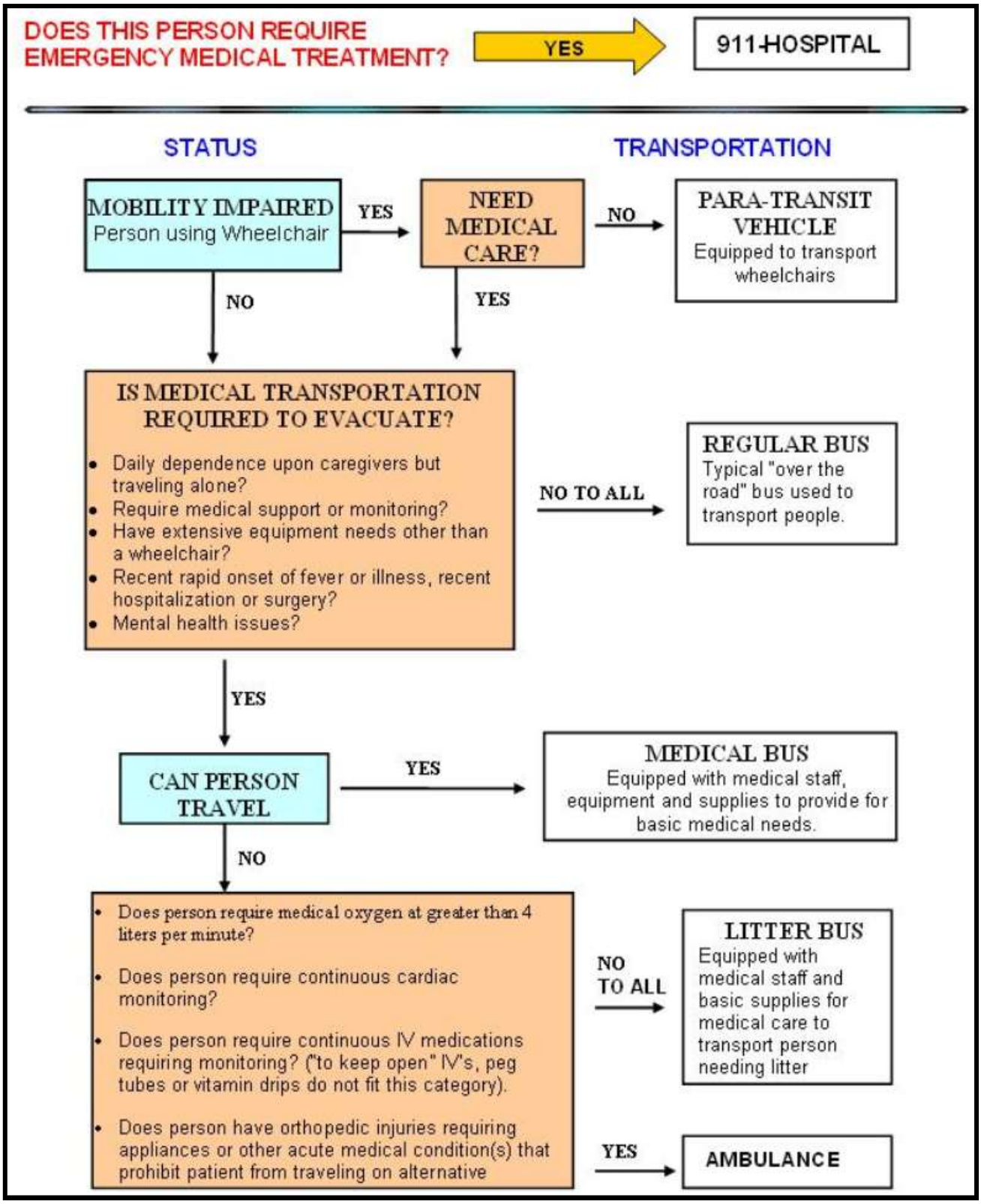
    c. Identify populations requiring neonatal intensive care transportation.

18. Provide patient data and transportation assets departure times to reception sites utilizing manifests, TexasETN, WebEOC, EMTRAC et al as appropriate.

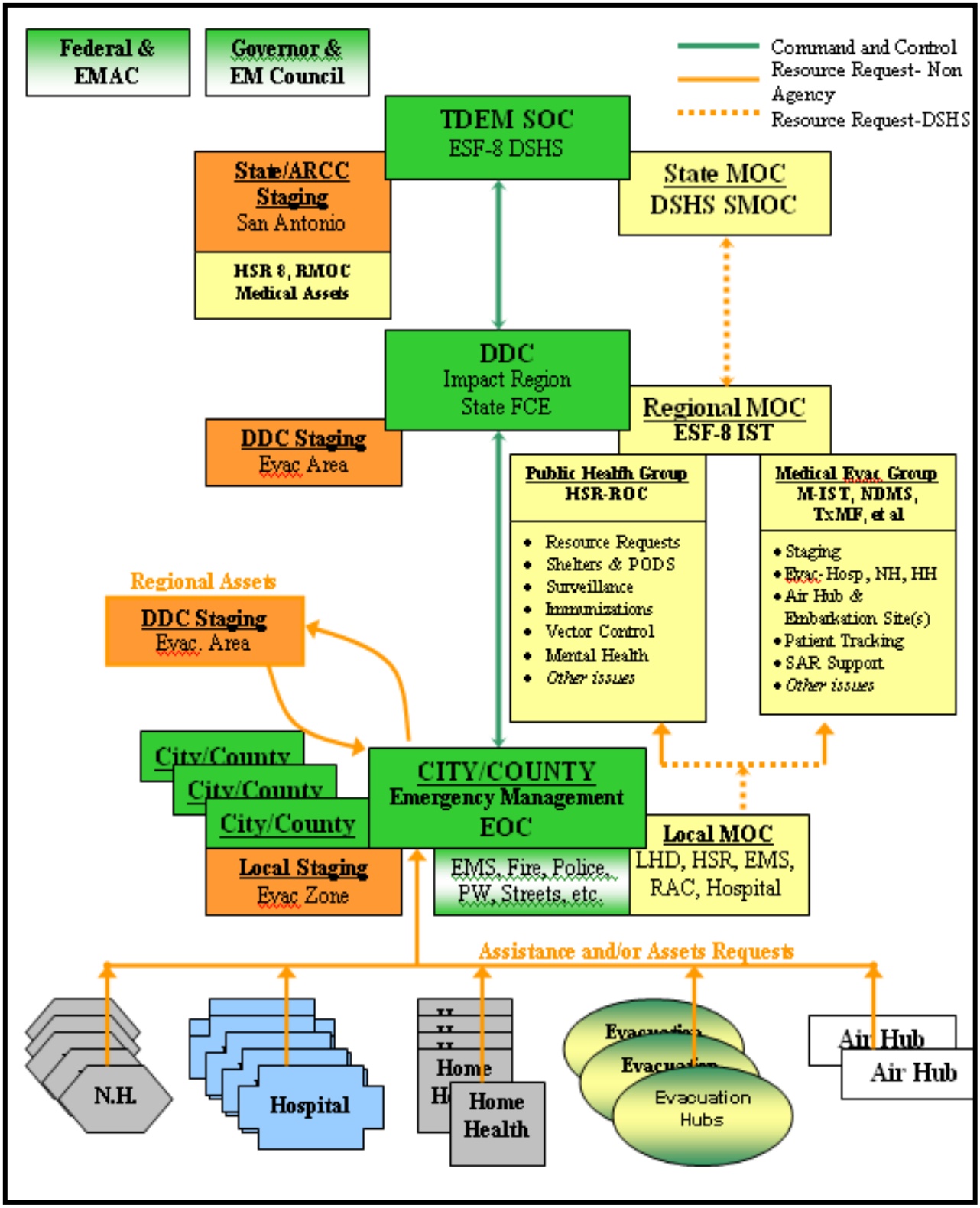
19. Monitor dispatch plans and mission completion.

20. Estimate and coordinate mission discontinuation of evacuation transports.

ATTACHMENT 5 – MEDICAL EVACUATION TRANSPORTATION GUIDELINES



ATTACHMENT 6 - ESF-8 COMMAND, COMMUNICATIONS, COORDINATION



ATTACHMENT 7– PATIENT MOVEMENT REQUEST FORM – PMR
14 STEP FLOW PROCESS

The Patient Movement Request PMR is a fluid document, which does not provide exact patient listings until just prior to the decision to evacuate a specific facility.

Once submitted the PMR follows the following process.

A. Notification Process Begins

1. DSHS will advise Emergency Management and RACs to inform hospitals that the evacuation forms are available through their local EOC, in WebEOC, on the PHIN and or the DSHS Website.

a. Patient Movement Request Form – PMR.

b. Aeromedical Evacuation Preparation Checklist (will be submitted upon receipt of a PMR Form 1).

2. Evacuating hospitals requesting evacuation assistance will complete the PMR and forward to their respective EOC/MOC. EOC Staff (Medical Branch or MOC) will review forms and determine if evacuation mission can be carried out utilizing local resources (either ground or small air assets) or determine if they must request further support and assistance to carry out evacuation missions. This may activate the Texas Military Forces large airt assets OR initiate the request for the NDMS large air assets.

3. EOC/MOC with RAC assistance will review the PMR for completeness and:

a. Forward to the DSHS SMOC via e-mail to:
   1) operations@dshs.state.tx.us or
   2) FAX the document to 512-776-4980

b. Advise DDC that the there has been a request for Federal assistance and that Form-1 has been forwarded to the DSHS SMOC.

c. Advise the State EOC that the there has been a request for Federal assistance and that Form-1 has been forwarded to the DSHS SMOC.

4. The DSHS SMOC will review the forms received and forward the completed PMR to the Joint Patient Movement Team (JPMT) who is collated in the DSHS SMOC. The JPMT will transmit the requirement to GPMRC.

5. GPMRC will create the "Patient-Mission Manifest (aka. "Pull Patient-Mission Assignment") and forward back to JPMT in the SMOC, who in turn will provide the list to the ESF-8 desk at the DSHS SMOC.

6. The DSHS SMOC Evacuation Branch will report as follows:

a. Post the *Patient-Mission Manifest - "Pull Patient-Mission Assignment"* to the designated EOC (MOC or RAC) e-mail address OR FAX the document as directed by the requesting DDC/EOC.

b. Notify the evacuation regions DDC and EOC of the Patient-Mission Manifest - “Pull Patient-Mission Assignment” so they have visual on the timing of the evacuation operation.

c. Notify the MOC-RAC Points of contact of the Patient-Mission Manifest - “Pull Patient-Mission Assignment” to notify hospitals so they have visual on the timing of the evacuation operation.

d. Notify the Air Hub Incident Commander of the Patient-Mission Manifest - “Pull Patient-Mission Assignment” so they have visual on the timing of the evacuation operation.

e. Post the Patient-Mission Manifest - “Pull Patient-Mission Assignment” in the appropriate event file.

7. The EOC (with MOC and/or RAC support) will notify hospital of estimated patient transfer timeframe. Hospital will prep patient and complete Aeromedical Evacuation Preparation Checklist for each evacuated patient.

8. Once the *Patient-Mission Manifest - “Pull Patient-Mission Assignment”* has been received at the Air Hub, the Incident Commander at the Air Hub (AMP) will notify the EMS Air Hub Ambulance Transportation Team (AHATT) and the Medical Incident Support Team (M-IST) of the operation start time who will print the Hospital Aeromedical Transfer Forms including the patient name and the name of the evacuating hospitals that are assigned to the arriving aircraft. The EMS AHATT and the M-IST will distribute the Hospital Aeromedical Transfer forms and maps of the area hospitals to the ambulance driver.

B. Evacuation Movement Begins

9. EMS AHATT will coordinate patient pick up via ambulances or buses. Upon arrival at hospital, the evacuating hospital will complete Hospital Section of Hospital Aeromedical Transfer Form and keep a copy. EMS AHATT will then transport patients to the Air Hub. The ambulance crew will complete the EMS Section of Hospital Aeromedical Transfer Form and keep a copy of the Aeromedical Transfer Form upon deliver of patient to Air Hub.

10. Patient and equipment is checked in at Air Hub and validated/processed for movement by aircraft by MASF. MASF completes Airworthy Section of Hospital Aeromedical Transfer Form and preps patient for air transport to a receiving Federal Coordinating Center (FCC). If the patient is not suitable for transport, the Hospital-DRC or designee will be notified for alternative placement

11. As a rule of thumb, equipment goes along with patients. Receiving hospitals will coordinate with evacuation hospital for return of equipment. If equipment is not airworthy, equipment will be replaced with more appropriate air-worthy equipment (known as Patient Movement Items -PMI). Both sets of equipment (replaced and new) will be transported with the patient. Receiving hospitals will coordinate with evacuation hospital for return of equipment.

12. The EMS designee or the M-IST designee at the Air Hub will monitor Patient-Mission Manifest - “Pull Patient-Mission Assignment” list to verify patient destination (i.e. returned to hospital OR transported to FCC destination hospital).

13. Air Hub Incident Commander verifies accuracy of final Patient-Mission Manifest - “Pull Patient-Mission Assignment” list for each plane. M-IST forwards Patient Manifest to the DSHS SMOC via e-mail to operations@dshs.state.tx.us shortly after “wheels up” on the airplane. MASF will notify GPMRC of any changes. Final Pull Patient List should be catalogued under the folder “Wheel’s Up” in the appropriate event file in the SMOC. Hospitals should also be notified of this final list through email notification.

14. Upon arrival of patients at the receiving FCC and once final hospital distribution has occurred, the FCC Officer will create and forward the Final Patient Destination form to Federal ESF 8 partner in the SOC and this list shall be forwarded to the DSHS SMOC operations Branch. State EOC will forward the Final Destination Form to the state, DDC, and EOC, and GPMRC points of contact. The local EOC (MOC and/or RAC) will forward the Final Patient Destination Manifest to hospital.

ATTACHMENT 8 – PMR FORM FLOW PROCESS

Diagram 1 – PMR Flow Process

For an Air Evacuation the Texas Military Forces and the NDMS must be able to coordinate the arrival of patients to an Air Hub with an appropriate C-17 or C-130. In order to do this they must have notification of the patients so they can build the "Mission Assignment". The following diagram provides a pictorial on the operational steps for the Patient Movement Request Form (PMR) and the Patient-Mission Manifest Air NDMS flow process. It appears to be quite complex but it actually follows the 14 step process found in ***Attachment 7.***

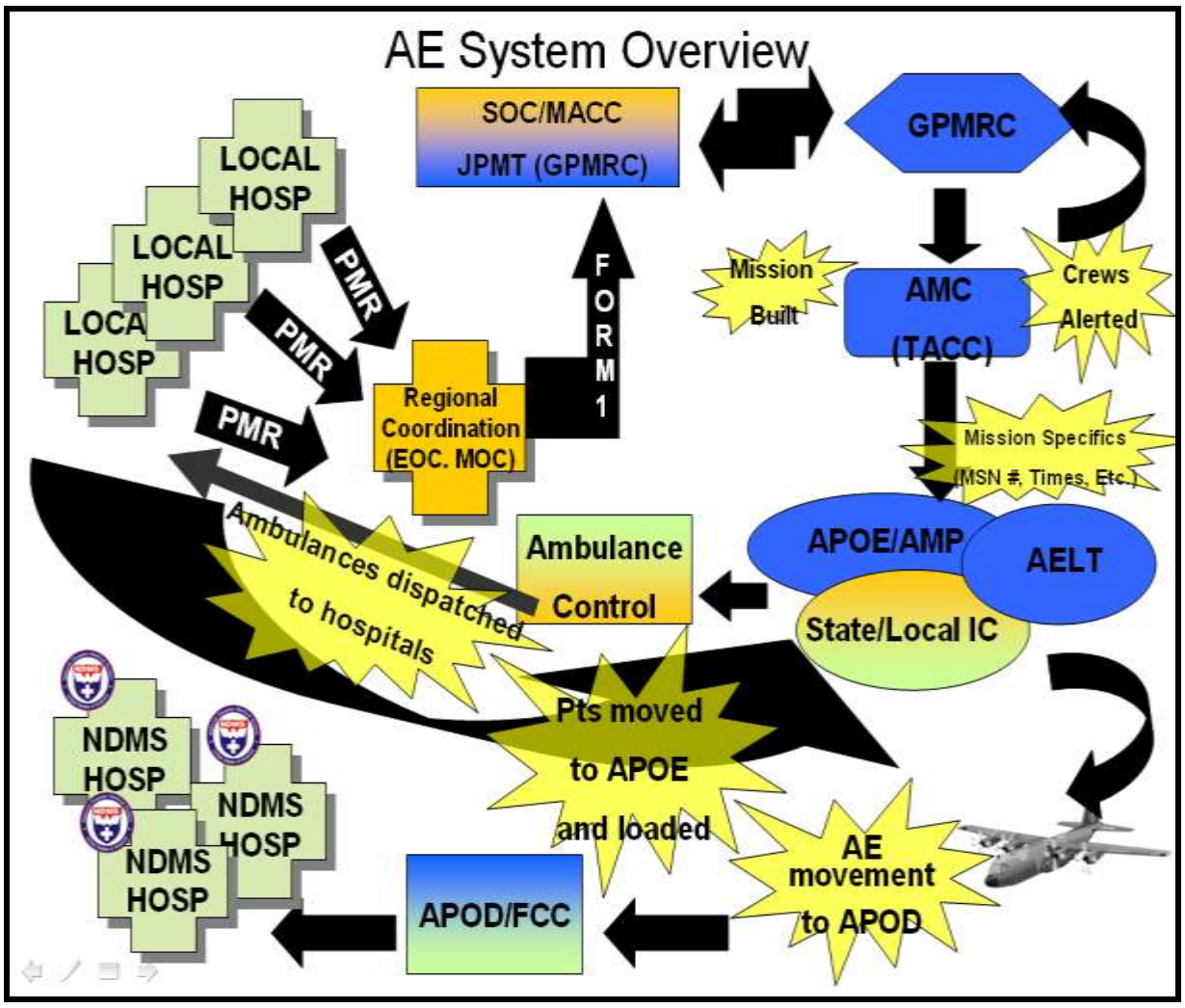
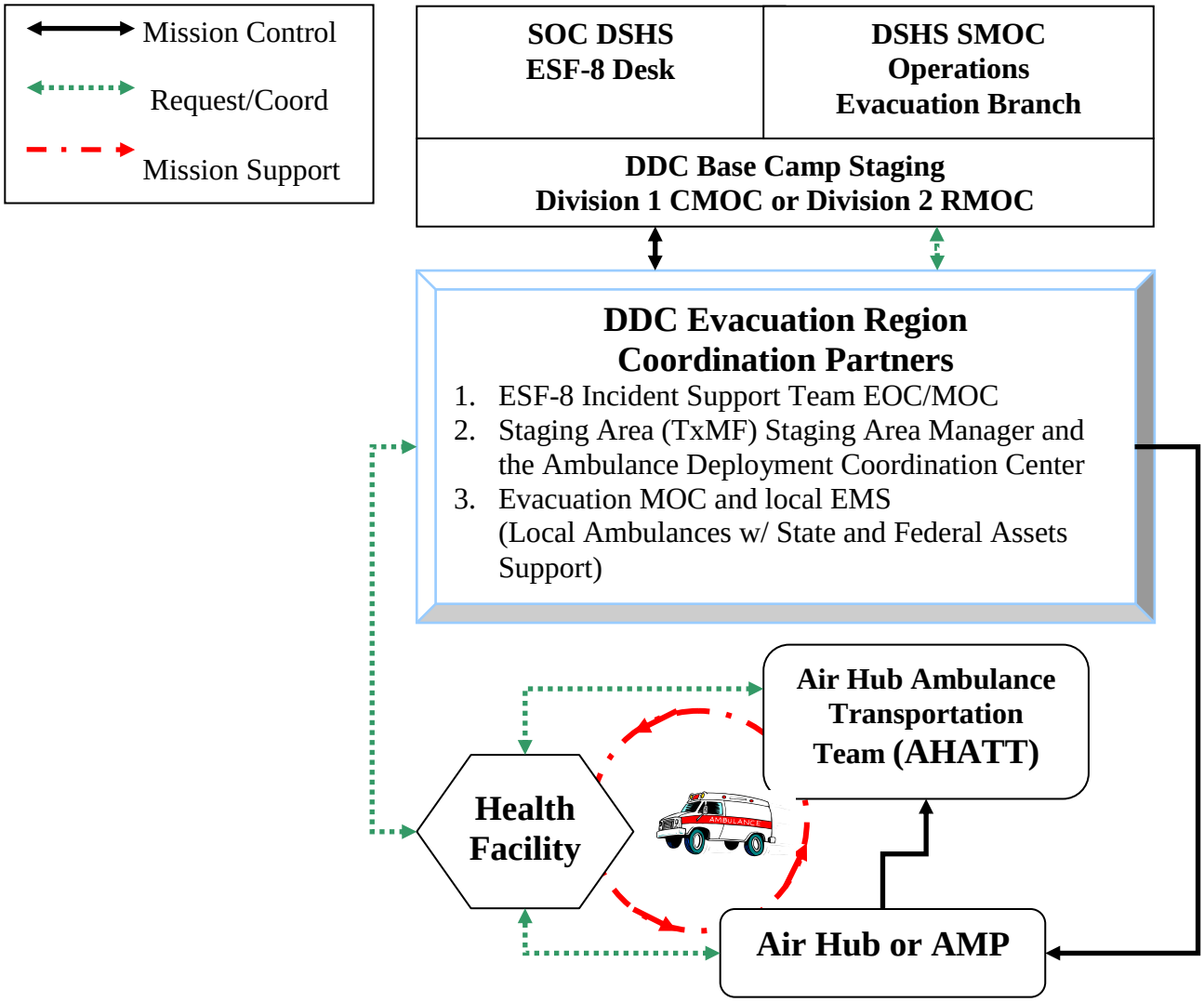


DIAGRAM 2 – AIR HUB AMBULANCE TRANSPORTATION TEAM

The diagram is a pictorial of the process of requesting and deployment of transportation assets (ambulances) from the Staging Area, to the hospitals for patient pick up, to the Air Hub. The National Disaster Medical System (NDMS) system will receive the patients and transport them to other NDMS facilities in Texas or across the nation if necessary. Non-NDMS air evacuations (TxMF, etc.) will utilize this same process. In an established air operation, ambulances will be deployed from regional staging to support the Air Hub Ambulance Transportation Team-AHATT. These units will have the specific mission to pick up patients from an evacuating medical facility and transporting them to the designated Air Hub. If additional ambulances are required for the mission, the Ambulance Deployment Coordination Center will deploy additional ambulances from a staging area to the Air Hub. Note: This is not the process for submittal of PMR, this is the operational response to the submittal of the PMR. The map shows coordination points that tell the ambulance crew when to pick up the designated patient(s). This is the process that is utilized once an air evacuation has begun.



ATTACHMENT 9 - AEROMEDICAL EVACUATION PREPARATION CHECKLIST

FIXED-WING Aeromedical Evacuation (AE)

PREPARATION CHECKLIST for Civilian Patients (Disaster Evacuation)

ITEM	COMMENT	ACCOMPLISHED	
		YES	NO
Personal Documents	Personal (Photo) Identification		
	Emergency (Family) Contacts		
Appropriate Medical Records	Patient Care Summary		
	Patient Care Requirements		
	Medical Alert Tags or Bracelets		
	Prescriptions Authorization		
	X-Rays (if required)		
	Insurance Card or Paperwork		
Medications (Oral and/or Intravenous)	72 hour supply		
Dietary Special Needs	72 hour supply		
Appropriate Clothing (for cold aircraft or inclement weather)	One commercial aircraft size carry on item (Identification attached)		
Authorized Litter			
Durable Medical Equipment • **Portable Oxygen (subject to authorization for flight)** • **Other Durable Medical Equipment** _____ _____	To support patient during ground transport to medical airhead only. Hospitals should label all equipment they want returned post event.		
Patient Evacuation Kit	Water		
	MRE X 3		
	Blanket (1)		
	Toiletries		

ATTACHMENT 10 – NURSING HOME EVACUATIONS

1. Nursing homes have transportation agreements in place to evacuate their residents in case of emergency. However, given a large-scale disaster affecting multiple counties in the coastal areas of Texas, a portion of these nursing homes will most likely not be able to procure their pre-arranged transportation.

2. Most nursing home patients will be transported to alternate facilities with which the nursing home has a pre-arranged agreement. The only nursing home residents that will not be transported to an alternate nursing home facility are those who decompensate, or whose current medical condition warrants transfer to the hospital evacuation process. This transfer will be done by ambulance. Non-ambulatory patients will be transferred to partner institutions via ambulance, bus, or properly setup ambus-bus. Ambulatory patients will be transferred via ALS Bus, and those who are wheelchair dependent may be transported via a Wheel Chair Vehicle (WCV).

   a. Buses
      The State of Texas and the federal government utilize contracts with coach bus companies to procure buses for medical evacuation (hospitals, nursing homes, and general population without transportation of their own). Many of these buses will have lifts or ramps, making them wheelchair accessible. Each bus can hold up to 40 passengers. These buses will have medical personnel and supplies to provide in-transit care, but medical facilities will be expected to supplement those staff and supplies with their own.

      If a request is made for these assets, command and control of these assets will be provided by the state.

   b. Para– transit Seats Wheelchair Vans (WCV)
      For those who need to be transported in wheelchairs, but do not need to be on a stretcher (necessitating ambulance transport) can ride in para-transit vehicles. These are also referred to as Wheelchair Vans or WCV. Many nursing homes have their own WCVs, and use them to transport their residents for routine trips. However, if state assistance is needed for an evacuation, federally contracted para-transit seats will be available. The contract presently provides 3,500 seats that can be used for the evacuation of nursing homes, hospitals, and home health people with medical needs that are wheelchair dependent. NOTE: 3,000 para-transit seats generally require multiple trips from the evacuation area to receiving sites. This means that long term care (LTC) facilities will be asked to evacuate early.

   c. Advanced Life Support (ALS) Ambulances
      Currently the state has approximately 200 ambulances under an MOA that can be deployed for medical evacuations. As experience has shown, approximately half of these assets can be activated and deployed into a major disaster. These ambulances can carry two passengers per trip, and come with drivers and the necessary medical personnel to provide in-transit care. A federal contract may add an estimated 300 to 500 ambulances to the medical transportation pool.

   d. Evacuation Staffing
      Having available staff to load, unload, and provide in-transit care for nursing home residents is a vital part of a safe and effective evacuation. A general guide for the staffing

requirements is a ratio of one staff member to every ten residents. In addition to nursing staff, augmentation may be required from the county and/or volunteers.

Transportation Requirements for Nursing Homes (This form is subject to change)				
Nursing Home Census Details		**Transport Vehicle Needs**		
TSA Region or City/ Counties	**Census**	**Ambulances (2per vehicle)**	**Para-Transit Seats**	**Buses (Patients and Staff)**

3. Nursing homes are responsible for developing and procuring the necessary assets for their evacuation plans. There is an expectation that many nursing homes will succeed in their efforts to self-evacuate; however, those that cannot may request assistance from the city/county. If city/county transportation assets are not available, state assistance will be requested through the DDC.

4. Nursing homes, with input from county officials and emergency personnel, will make the determination to evacuate or to shelter-in-place (SIP). Nursing homes will:

   a. Implement nursing home emergency management plans.

   b. Activate existing memorandums of agreement or contracts to evacuate patients to pre-identified facilities.

   c. Notify their respective city/county EOC on their decision to evacuate.

      1) If unable to evacuate with pre-identified assets, request evacuation assistance from the city/county EOC.

      2) Notify the EOC on the status of their nursing home, the number of patients that require evacuation, the type of patients and whether they are ambulatory or non-ambulatory.

3) The EOC will forward the request to the DDC.

d. The local EOC-MOC and the DDC-MOC will coordinate the deployment of ambulances and buses from the staging/dispatch point to evacuate nursing homes.

e. The nursing home will contact the EOC when transportation arrives and departs, and when the mission is complete.

f. The EOC/DDC/Regional MOC is responsible for:

1) Keeping situational awareness, keeping accurate records of nursing homes that have evacuated and nursing homes that have chosen to shelter-in-place (SIP).

2) Providing non-medical personnel to assist in the loading of patients.

3) Providing evacuation transportation.

g. If county or contracted transportation resources become overwhelmed, the EOC will forward the request to the state through the established communication and asset request process. The state will work with the DDC to procure the requested transportation assets utilizing additional state and federal contracted assets. Transportation will be with standard coach buses, Para-transit seats, ALS Buses, or contracted ambulances.

ATTACHMENT 11 – TEXAS 213RR - COPY

RESOURCE REQUEST MESSAGE ICS-213RRFF TX

Note to Requestor: fill in all shaded areas for expedited service

INCIDENT NAME:	DATE & TIME:	RESOURCE REQUEST #:
COUNTY TRACKING #:	CITY TRACKING #:	DDC TRACKING #:

REQUESTOR

ORDER NOTES: Use additional forms when requesting different resource sources of supply

Qty.	Unit Type*	Kind (NIMS Rec)	Type (NIMS Rec)	Detailed Item Description (vital characteristics, brand, spec, size, etc.)	Cost (if known)	Demob Item? **

*** Unit Type: (case, ea, pallet, etc)** ****Demob: Will the item need to be included in Demobilization?**

Point of Contact Name:	Point of Contact Telephone #:	Facility Name:	
Physical Address:	City:	State:	Zip
Requested by (Name & Position):	Contact Telephone #:		Priority:

Supervisor Signature/ Approval:	X	Date: / Time:
Section Chief Signature/ Approval:	X	Date: / Time:

LOGISTICS

Logistics Order #: ☐ Equipment ☐ Supplies ☐ Personnel

Name of Supplier:	Point of Contact:	Phone Number:
Fax Number:	Point of Contact e-mail:	

Notes:

Logs Chief Signature/ Approval:	X	Date: / Time:

Order sent to: (mark all that apply) ☐ SPUL ☐ PROC ☐ SMOC ☐ DDC ☐ OTHER:

FINANCE

Reply or Comments from Finance:

Finance Chief Signature/ Approval:	X	Date: / Time:

Request filled by: ☐ Local ☐ SMOC ☐ DDC ☐ SOC

Route to: ☐ Logs ☐ Finance ☐ Requestor ☐ Documentation

Additional Notes/ Details: